STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION MEETING

July 7, 2004

Commission Members Present:

Joan F. Henneberry (Chairperson)
Clifford E. Barnes, Esq.
Donna A. Boswell, Ph.D., J.D.
James Chase
David L. Clark, R.Ph., M.B.A.
Jay D. Currie, Pharm.D.
Barbara Edwards
Nora Dowd Eisenhower, J.D.
Janice O. Faiks, J.D.
Dewey D. Garner, Ph.D.
Karen Greenrose, R.N.
Laurie Hines, J.D.
Julie A. Naglieri
Dennis O'Dell
Robert P. Power, M.B.A., C.B.E.S.
Susan C. Reinhard, R.N., Ph.D.
Sybil M. Richard, J.D., M.H.A., R.Ph.
Elizabeth J. Rohn-Nelson
Marc S. Ryan, M.P.A.
Linda J. Schofield, B.S.N., M.P.H.
Martin Schuh, M.B.A.

CMS Staff Present:

Deirdre Duzor
Marge Watchorn
Christina Lyon

I N D E X

STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION MEETING

July 7, 2004

I N D E X (Cont'd.)

Formal Presentations(continued)

Open Session for Public Comments

Closing Remarks

KEYNOTE: "---" denotes inaudible in the transcript.
"*" denotes word was phonetically spelled.

M O R N I N G S E S S I O N

(9:03 a.m.)

Welcome Attendees and Review Ground Rules

Joan Henneberry, Chair

MS. HENNEBERRY: Good morning, everyone. My name is Joan Henneberry. I am the Director of Consulting and Research at Policy Studies, Inc. in Denver, Colorado. I am very happy to be back here in Washington, DC for a few days. I am one of the few people in the world who don't mind this humid weather.

We will be doing formal introductions of the entire commission after we are all actually sworn in. So I am going to warn you right now our morning agenda might be just a little disjointed because we are waiting for Dr. McClellan and then we will be waiting for Secretary Thompson. So we will go through as much of the agenda as we can before they arrive, and they we do have to take a short recess until we are all officially sworn in before we begin the official business of the commission. But I do welcome you, and I thank Secretary Thompson for inviting all of us here to be part of this.

Let me tell you a little bit about how the day will go after the swearing in. Today as you can see from the agenda is mostly prepared remarks. Individuals and

organizations were invited through a notice in the Federal Register in June to come to this meeting and provide remarks and testimony, share research and information, so we will -- most of the day will be presentations from those individuals. They will each speak for a short period of time. Then the commission members will be invited to ask questions of each of the presenters, and if there is time after each presentation I will invite the visitors in the audience to ask questions and ask for clarifications as well. At the end of the day we have left time at the end of the day for those of you in the audience to ask additional questions or make additional comments. Those will be very short, and toward the end of the day when we have an afternoon break I will ask those of you in the audience if you wish to speak so that I have a sense of how many of you and we can allocate that time appropriately to make sure that everybody who does want to make a comment will have an opportunity to do that.

Tomorrow the commission will be meeting together in a closed meeting to actually begin our work. We have a lot of work to do before our next meeting, which is probably going to be in the middle of October; and we will be working feverishly all summer long in subcommittees collecting additional information, asking more questions,

and that will also be an opportunity for other individuals or organizations who have comments of think about issues that they want to bring before the commission. You are welcome to do that, and you can contact Marge Watchorn, who is in the corner there. She is our primary contact at CMS and really is the person who has helped pull this altogether. You can see her at the end of this meeting or anytime during the day today if you think that you would like to provide us with additional information after this meeting here in Washington, DC, and we are certainly -- we welcome as much information and help as we can get.

The deliberations today are being audiotaped for transcription for commission members. Please remember these are turn on and off microphones, so you do have to push this little button here and then turn it off after you have spoken. We do ask also for commission members and if we have time for audience questions to please give us your name and affiliation so that the transcribers can include them in the written copies as well.

I am going to go ahead and jump to a little review of the agenda since we are waiting for Dr. McClellan to get started. If you look through, again as I said, most of this after the swearing in when Secretary Thompson will be here, and he will be making some other remarks as well.

We will begin our formal presentations, and they are a mix of presentations from researchers and private sector and state organizations, as is the makeup of the commission actually. The first presentation will be Kimberley Fox from Rutgers. Then we will break for the commission to actually work through lunch. Then in the afternoon we will have four more presentations. One from Kathleen Mason from the New Jersey Department of Health and Senior Services, Jack Hoadley from Georgetown, another break, Tom Morrison from CVS Pharmacy, and then public presentation also be Evelyn Gooden, state representative from AARP in Illinois. Then we will have the rest of the day will be open to those of you in the audience who wish to make additional remarks or ask questions of the commission or any additional questions of the researchers or presenters that are here.

Again, as I said, we will be meeting most of the day tomorrow and then follow up with phone calls, conference calls of the full commission as well as the subcommittees that we form during the day tomorrow. So does anyone have any questions or commission members any comments about format, agenda? Marge, did you have anything you wanted to add? Okay. Then we are way ahead of schedule because we are subject to the schedules and traffic of Washington, DC and schedules of the HHS officials. So we

will just take a little break here until Dr. McClellan joins us and we will resume. Thank you.

(Whereupon, a break was taken.)

MS. HENNEBERRY: Again good morning, everyone. We have now been joined by some additional CMS officials. I want to make sure you see Denis Smith in the back there, and we have been joined by Dr. Mark McClellan, the Administrator for the Centers for Medicare and Medicaid, who will be making some remarks and reminding us of what our charge is here on this commission. We are very happy to have you here with us this morning.

Review SPATC Charter, Part D Benefit

Mark B. McClellan, MD, PhD

DR. McCLELLAN: All right. Joan, thank you very much. It is pleasure to be here with you all as well. This is an important meeting. One of the real pleasures for me about my job at Centers for Medicare and Medicaid Services is the opportunity to work with people from around the country, and especially people from various states that have long been at the forefront of coming up with better ways, creative ways, innovative ways of getting health care assistance to people who need it the most. One of my other favorite activities in this new job is implementing some of the very important new provisions of the Medicare law that

are bringing Medicare up to date in terms of the kinds of medicines it covers, the kinds of coverage it provides to our seniors and people with disabilities. So this meeting is a special privilege because it gets to bring both of those kinds of activities together.

So let me join with Joan and soon with the Secretary in welcoming you to this first meeting of the State Pharmaceutical Assistance Transition Commission. I particularly want to thank the Chairperson in advance, Joan, for her hard work. There is a lot that we are asking you to do in a short period of time, and I also want to thank each of you for being here today and for being willing to serve on this commission and providing some input into this valuable work on behalf of the seniors and the states that have been helping them to date in providing prescription drug assistance around the country.

The makeup of this commission has been very impressive to all of us. You all are drawn, as you I am sure noted in your opening of this meeting, you all are drawn from a broad array of backgrounds, all of which are relevant to the effective implementation of the new Medicare prescription drug benefit. People who are experts in pharmacy services, pharmaceuticals, who have extensive experience with state programs, who have extensive

experience with working with the elderly, who have academic backgrounds of great relevance to the questions that the commission will be dealing with. I think it is a terrific and diverse group, and I want to thank all of you for your commitment on top of your day jobs to be here to help us implement the new law effectively.

This is a very important law at a very important time. These are as the President said, as Secretary Thompson has said, these are the biggest improvements in the Medicare program since it was established in 1965. These improvements are particularly important for states that until now have been on their own too much when it comes to providing assistance for Medicare beneficiaries who are having trouble with drug costs and need drug coverage, and it is especially important for our seniors and people with disabilities of limited means who are the most vulnerable to high drug costs and have the most to gain from having access to affordable coverage.

We have already started implementing some new steps in this law. Many of you are familiar with the Medicare drug card program which is giving seniors for the first time the ability to band together to negotiate lower prices from drug manufacturers and giving them the information they need to be better comparison shoppers. We

have seen already prices decline for seniors who participate in this program by more than 15 to 30 percent off retail prices. You know, some seniors and people with disabilities are able to get some discounts on their own through pharmacy cards, but the recent studies have shown that the drug card prices are 10 to 18 percent below those typical discounts that seniors are able to receive and that all people in this country are able to receive on their own, and the discounts for generic drugs are even larger. We have got more 3.7 million people enrolled in this program now, more than 25,000 signing up every day and starting to get savings. A lot of those are people with low incomes who qualify not only for the discounts, but also qualify for $600 in financial assistance and wraparound discounts from many drug manufacturers if they spend that full $600 financial credit that is available this year and the next $600 that is available next year.

So we are working hard already to get this help out to beneficiaries who don't have good coverage now in anticipation of the full benefits starting in 2006. A good part of this has been working with states that already have state prescription assistance programs established. There are many of these SPAP programs that are sponsored by PBMs or other card organizations that are also participating

in the Medicare card program. So in many states we have been able to set up a pretty seamless addition to the state's coverage of this $600 assistance and of the potential access to further manufacturer discounts. So we have made some starting steps towards getting the benefits of the new law out to beneficiaries.

We are working on other programs right now. Many of you have heard about the new demonstration program for drugs that are alternative to drugs that Medicare covers now and are delivered in physician offices, drugs for cancer care in many cases, drugs for rheumatoid arthritis, multiple sclerosis, other serious conditions that will be expanding to all beneficiaries in the coming year with the 2006 benefit. Well, in these initial steps it has been very clear to me and everyone in the Department that the states have a major role to play in helping us make this transition happen smoothly, and our intent here is to provide some real relief and better coordination with the states. Up until now, as you know, without a Medicare drug benefit, states have been facing a primary responsibility through Medicaid and through the state prescription assistance programs to provide help with drug costs for beneficiaries who need it the most. We are planning on changing that with the implementation of the new law, and in our analyses of the

law which we have been working hard on since the law was passed in December of 2003, we believe that between the comprehensive new benefit for low income seniors, the comprehensive coverage for people below 135 percent of poverty, the substantial additional help even beyond the standard Medicare drug benefit for people up to 150 percent of poverty, that means that states can come out ahead. The so-called clawback funding for the states doesn't offset those full savings. States also get benefits under the new law because of the employer assistance that the law provides. So that for state retirees whose drug coverage the states have been paying, this is a big cost for states today, there will be new billions of dollars in new financial assistance going to the states to help them defray those costs that they face as well.

There are some new costs that states are going to be facing under this program. One is the, quote, unquote, "clawback" that I mentioned. That is only for a portion of the expected savings to states as a result of the Medicare program taking over primary responsibility for drug coverage for seniors and people with disabilities. There may also be some additional state costs as a result of more people signing up for benefits. You know, when you make better benefits available that tends to bring out more

people, and I think frankly that is a good thing if we can get more people who are eligible signed up for low income assistance programs. But we again here, even with this woodwork effect, I think the overall net effect on states is a positive one; lower costs for them so that their dollars can go further in providing benefits to the residents of the state.

But even with these new benefits enacted in the law, there is a big difference between passing a law that intends to bring substantial relief and actually delivering it to the beneficiaries who are intended to gain from it and providing states with the relief from these financial costs, and that is why we need you. We need you to help us make sure that lower income beneficiaries get the new coverage under the law without any substantial new paperwork, that the law is implemented as intended to help out the states as well. So, to make sure that people realize the new benefits of the Medicare law, this commission has been asked by and required under the new Medicare Modernization Act to help make sure that low income Medicare beneficiaries who currently receive drugs through state-sponsored programs will be able to transition smoothly into the Medicare prescription drug plans without disruption in their coverage and within disruption in their access to

care. So all the ingredients are there to make this happen, but a law written on paper is very different from the delivery of actual effective benefits in a timely way in practice. We are under a tight time frame to make this work. We need to get this program implemented and up and running effectively in just a year-and-a-half from now.

I hope this commission is going to work, and expect that it will work closely, with everyone in our agency at CMS to help identify and resolve the transitional issues that both low income beneficiaries and states may face as we implement this important new benefit. The Secretary will be here shortly. He is also very enthused about the work of this commission and he is going to have more to say about some new help, some additional help that we will be providing to states to make this transition work smoothly that we want you all to be aware of and help us to use as effectively as possible.

In the course of addressing these issues we will ask a set of questions. Some of the most important questions I think include questions about how the states that want to wrap their assistance programs around the Medicare prescription drug plans can do that as effectively as possible; how can we simplify the enrollment process including reliance on some new tools we have like working

with the Social Security Administration, which will be providing some important help in identifying and enrolling low income beneficiaries using auto enrollment processes for beneficiaries who have limited Medicaid coverage, QMB, SLMB and the like; what are the technical and data-related issues that are facing states and their pharmacies and the prescription drug plans that we could address to help provide the information that can support a smooth transition. Questions like these, and there will be many others. To address these issues we really encourage you to take a comprehensive approach. As many of you know from your background in working on these issues, the more we focus on the needs of the beneficiary, the details of the ways that state programs have evolved to meet those needs, and combine that with the mechanics of the new Medicare prescription drug law, I think the more effective we can be in carrying out the charge of the commission.

We do expect the commission proposal to address the transitional issues and the subsequent report that will be going to Congress will help us tremendously in preparing both our agency and Congress and everyone else who are involved in this transition to the important new drug benefit to make that happen as smoothly as possible. I think there have been some good experiences already, some

that we can certainly learn from as well in how we have interacted with states in getting the Medicare drug cards up and running for beneficiaries in SPAP programs who are also eligible for the $600 Medicare transitional assistance. So there is some experience base that we can use in these efforts already, and I am sure that you all through your tremendous wealth of experience in dealing with beneficiary assistance programs for prescription drugs and dealing with states on these issues will be a tremendous help as well.

So I am glad to see you all here today. I am also glad to see so many interested members of the public here in our audience. I know that everyone is coming ready to work constructively together to provide your insights, your experience, your knowledge on how we can work most effectively to implement the new law. We need your help and we need your help right away to take full advantage of all these new features in the Medicare Modernization Act to get comprehensive and better drug coverage to the Medicare beneficiaries in this country who need it the most. So, Joan, thank you for the opportunity to be here with you all today. I wish you all well. I will be tracking, as will many of the CMS staff be tracking, your work very closely as we move forward on implementing the new law, and I am very confident that we are going to benefit from your help. I am

looking forward to working with all of you, and I have got a few minutes for questions now if you have any about the new law, about your roll, about any other topics that may be of interest to you as you get started on your work.

Opened for Questions and Answers

MS. HENNEBERRY: Thank you, Dr. McClellan. Do any of the commission members have any questions? Linda.

MS. SCHOFIELD: Can you talk a little bit about, and maybe you are going to address this later, but time lines and how the work of this group is going to inform and shape your regulatory process?

DR. McCLELLAN: Absolutely. I think we will hear a little bit more later about specific time lines, and you all can discuss that as well, but basically the sooner we can get input from you the better. We are, as you might imagine, working hard right now on proposed regulations for implementing the new features of the drug benefit and the new assistance to states, and during the deliberations of your commission I am sure you will have an opportunity to review our proposed rules after they come out and offer some suggestions along the way. Obviously the sooner you can get the work done the better in terms of having an impact on our regulations. I addition to the regulations, however, there will be a lot of just specific operational steps in terms of

interacting with states, guidance and advice that we can give to states on working effectively with us, other specific processes that we can set up within whatever regulatory structure we implement to work effectively with the states. So all of those steps I think you all can and should think about addressing, and I do want to emphasize the tight time frame that we are under. To deliver a drug benefit effectively in 2006 we need not only regulations in place well ahead of them, but also support systems for working with states and education programs and outreach programs in place, too. We are thinking, working hard on all those issues, and I am sure during the deliberations of the commission there will be a lot more interactions about exactly what we are doing and our efforts to incorporate your suggestions on how we can do it effectively.

MS. SCHOFIELD: So do you have a sense of when the final regs will be issued and how that lines up with our final report?

DR. McCLELLAN: We should keep working on that. I mean, as I said, we are going to try to work as quickly as possible to get the regulations done, but we want to make sure that we are incorporating your deliberations in the process. I think that the discussions, because there is going to be so much close interaction between the agency and

each of you through your meetings, the discussions you have at the meetings can also have an impact on our regulations even before the final report comes out.

MS. HENNEBERRY: Barbara, did you have question?

MS. EDWARDS: Dr. McClellan, could you say a little bit about how -- you emphasized how little time there is, what the huge challenges are, and also mentioned that in fact there are multiple federal agencies that have to be involved in this implementation along with all the states. Can you say a little bit about what the organization is at the federal level for crossing all those agency lines? Because that has been a huge concern I think in the past on projects, and if you could talk a little bit about what folks are doing to try to facilitate the communication and the cooperation.

DR. McCLELLAN: Yes. Very good question. We have interagency workgroups set up with all of the other agencies that we are interacting with in significant ways to implement the new drug benefit. One advantage of getting this drug card program in place now is that it is required us to get going on some of these interactions earlier. So, for example, we have been working fairly closely with other low income assistance programs across the government to make

sure that this new benefit is added on top of the other existing benefits. We are working hard with the Social Security Administration on the steps that they are taking to implement the law. We have also worked with the federal employees health benefits program and others. So there are interagency groups set up in all these areas that have work plans in place and are all working off time lines and critical path steps that need to be met in order to get the drug benefit implemented effectively in January, 2006. I think for your purposes if there are specific interactions with other agencies that you think we need to be aware of we definitely want to hear about that. My guess is that these interagency groups are already established to cover the other agencies that we need to work with effectively for the SPAP transitions, but I want to make sure that is the case. So there are interagency workgroups in place now, and we will obviously build on those in the coming year.

MS. HENNEBERRY: Susan.

DR. REINHARD: Dr. McClellan, we want to thank you from New Jersey for all the work that you did and your staff. I see Deirdre Duzor is here. She takes our calls very graciously.

DR. McCLELLAN: She does.

DR. REINHARD: We call her almost every day,

and it has been going well. But we are wondering about the assistance, the transition assistance that would go to states and when we could apply for that since we are anxious to hire staff and get going on some of those issues.

DR. McCLELLAN: We will have more to say about that very soon. In fact, you should ask the Secretary that same question in just a few minutes.

DR. REINHARD: Okay. Thank you.

MS. HENNEBERRY: Jim.

MR. CHASE: I am curious if in the charter it mentions potential legislation as well. Do you anticipate that there are some legislative changes that will be coming related to this, or is that --

DR. McCLELLAN: We haven't identified at this point any that we need particularly related to SPAP implementation, and obviously given the goal of, you know, not just talking about drug coverage and debating it some more, but actually providing it. We want to move forward as quickly as we can, and anything that we can do administratively to help get to that, you know, January 1, 2006 effective implementation date we want to undertake. I think legislation would add a lot of time to that, and I can't think of anything off hand, but obviously we want you all to look at the whole range of issues while keeping in

mind that we have got, you know, a goal not only of implementing this program effectively, but doing it quickly. Providing relief to the states beginning on January 1, 2006, and providing coverage to lower income beneficiaries on January 1, 2006. So I think everything that we can handle administratively to get to that goal we would really appreciate.

MS. HENNEBERRY: Any other questions from commission members?

(No response.)

MS. HENNEBERRY: Well, thank you, Dr. McClellan, for being here this morning.

DR. McCLELLAN: Great. Thank you, Joan, and again thanks to all of you for the work that you are doing on a tight time frame for a very important public health issue. We really appreciate your efforts. Thank you.

(Applause.)

MS. HENNEBERRY: We are expecting the Secretary momentarily. So if people would just sort of stay in the room and we will take another quick break as we work on the agenda.

(Whereupon, a break was taken.)

Swearing in the Commission Members

Honorable Tommy G. Thompson

MS. HENNEBERRY: Join me in welcoming the Honorable Tommy G. Thompson.

(Applause.)

SECRETARY THOMPSON: Joan, thank you very much. Thank you for your kind introduction, thank you for serving as chair, and thank you for your past experience at the NGA and what your current job is, and thank you for be willing to chair this and thank all of you for being involved. You have got a tough job. You have got to have a report out by January 1st. That is pretty fast for the government, and I really appreciate you willing to take on this responsibility and thank you so very much for doing that.

I am pleased to have everyone here today, and I am so thankful to all of you for your compassion for our seniors and your service to our nation. As you know, seniors are already saving money on their prescriptions thanks to the drug discount cards, and naturally they are grateful to Congress and President Bush for passing the Medicare Modernization Act last year. Since I worked on it and helped write it, I am very proud of that law. But I will tell you, the more I get involved in it, this is a very good law. The Medicare Modernization Act is a wonderful law, and it is going to do a lot of things, especially for

our seniors and especially for the low income seniors. Your responsibility is to help out the states, and I appreciate that very much. We are all looking forward to the advantage of the full drug benefit when it kicks in in January, 2006. This commission is going to help insure that low income Medicare beneficiaries who currently get their drugs through state-sponsored programs will not see their benefits reduced or their paperwork increased when the transition -- or when they transition to new Medicare. So you have got a simple job. You have got to reduce the paperwork and make sure that all the seniors get all of their benefits on time, and it is an awesome responsibility and I appreciate you for accepting it.

People who rely on state programs to help with prescription drugs should continue to get the help they need under the new Medicare Modernization Act, and your work is going to go a long way towards meeting that goal, and I appreciate it. We want you to examine different ways to ease the transition of low income Medicare beneficiaries from state pharmaceutical assistance programs. For example, you have to consider questions like how can states develop a single point of contact for enrolling and claims processing. Number two, how can states wrap around the new benefit by paying deductibles, copayments and drug costs for low income

enrollees, and you are also charged with finding answers to these important questions in submitting to them to the Department, to the President, and to the Congress by January 1st, 2005. No easy task, and I recognize that, but I know that all of you are up for this responsibility and will carry out your duties in a very efficient manner.

All of you come from different sectors of our health care system, so you bring different expertise to it which is badly needed. You represent a variety of fields and you bring valuable experience to this table to answer those questions. I am grateful to have such a talented and committed group of individuals helping us assist low income seniors.

I am also happy to announce today that we are going to release $125-million in grants in order to help educate -- and that is a lot of money, $125-million in grants to educate and enroll low income Medicare beneficiaries who currently get their drugs through state assistance programs. This is going to be money that is going out to the states and the states are going to have to apply for it, and you are going to also have to help us get this information out and get it back to the states. This money, which will be distributed to state assistance programs over the next two years, will make a huge

difference in insuring that all beneficiaries get the most out of their new drug benefit. Together with your efforts, these grants will help insure that low income beneficiaries understand the new Medicare and get the best possible savings that they possibly can.

So I thank you for your commitment. Your service will help thousands of your fellow Americans. It is also going to strengthen our health care system, and it is going to continue to bolster the compassionate spirit of our nation. When you look at the law that has been passed as I have, very frequently, almost daily, I come away with it and really recognize how important this is for low income seniors. Those individuals under 100 percent of poverty are going to get almost drugs -- 90-percent-plus of their drugs free of charge; those between 100 and 135 percent, over 80 percent; and those between 135 and 150 percent, over 70 percent. So this is a huge benefit to low income seniors, and you individuals have the opportunity to assist them. You are going the next step in how the state's assistance program is going to be integrated with the federal program, and it gives me just a great deal of appreciation and a great deal of competence knowing that you are going to set this up.

So congratulations, and now I would like to

swear you in. So if you would stand up and raise your right hands and recite the following oath we can get on with my number one responsibility this morning to this group, and I am honored to be able to do this.

(The commission was sworn in.)

Thank you very, very much, ladies and gentlemen. Have a good meeting and carry on. Thank you.

(Applause.)

MS. HENNEBERRY: Thank you. Are we going to do a photograph, Marge? If all the commission members want to come up behind me, and then we will take an official photograph.

(Photograph taken.)

Formal Introductions of SPATC Members

MS. HENNEBERRY: Okay. Now we will formally introduce to you the newly-sworn-in commission members. Again, for those of you who weren't here this morning, I am Joan Henneberry. I am from Policy Studies, Inc. in Denver, Colorado, and I am very pleased to be here and quite honored to be chairing this group. I have had the pleasure of working with some of the commission members before in my previous lives, and this is a great group. You have heard our charge, our charter and our time line, and I also mentioned to you this morning that we are planning to meet

again probably the middle of October, and we really feel we need to be done by then because of the need to edit and clearance processes and that sort of thing. So we really have a very, very short time line, and we will be working quite hard the rest of the summer and the early fall.

So let's just go around this way and we will let -- if each commission member -- actually I am going to wait until Marge sits down and joins me up here and let her introduce herself as well and each commission member introduce themselves and their affiliation. We will start with Marge.

MS. WATCHORN: Great. Good morning, everyone. My name is Marge Watchorn, and I am a member of the Medicaid pharmacy team in the Centers for Medicare & Medicaid Services. We are based in Baltimore, Maryland.

DR. GARNER: I am Dewey Garner. I am Professor of Pharmacy Administration at the University of Mississippi School of Pharmacy, and I represent I guess among others the community pharmacies in this country.

MS. ROHN-NELSON: Good morning. I am Elizabeth Rohn-Nelson. I was nominated by United Seniors Association, which is 1.5-million members in the United States, and so I am going to be your consumer representative.

MS. EDWARDS: I am Barbara Edwards. I am Medicaid Director in the State of Ohio, and Ohio is here as a representative of a state that has other SPAPs than those that are considered the official SPAPs, and we are very interested in the transition process around a variety of pharmacy programs in our state.

MS. GREENROSE: Good morning. I am Karen Greenrose. I am with the American Association of Preferred Provider Organizations, AAPPO.

MS. SCHOFIELD: Thank you. I am Linda Schofield. I am an independent consultant in the health care field. I work with pharmaceutical companies, insurance companies, state governments. I am a former Medicaid director myself, so interest in a wide variety of health care areas.

DR. CURRIE: I am Jay Currie. I am an associate professor at the University of Iowa College of Pharmacy and have worked extensively with community pharmacists over the last 10 to 15 years.

MR. O'DELL: I am Dennis O'Dell. I am with Walgreen Company and here to represent the community pharmacies where oftentimes beneficiaries most frequently come in contact with the health care delivery system.

MR. POWER: I am Robert Power. I represent

Health Partners, which is a regional health plan in the Twin Cities area of Minnesota. My primary interest in this process is about the integration between the drug benefit and regular parts A and B Medicare benefits. I am also hearing impaired.

MR. RYAN: My name is Mark Ryan. Good morning. I am the Secretary of the Office of Policy and Management in Connecticut. It is the Governor's staff agency in charge of budget and policy affairs. Thank you.

DR. BOSWELL: Good morning. I am Donna Boswell. I am a health care lawyer at Hogan and Hartson. I practice here in DC and I specialize in Medicaid and state issues, including state pharmacy program issues, largely for pharmaceutical and biotechnology companies.

MS. FAIKS: Good morning. My name is Jan Faiks. I am with the Pharmaceutical Research and Manufacturers of America, primarily working with states, state Medicaid agencies and state pharmaceutical assistance programs.

MS. DOWD EISENHOWER: Good morning. I am Nora Dowd Eisenhower, Secretary of Aging from Pennsylvania. The Department of Aging is a cabinet-level post, and it is manages the very large senior prescription drug program in Pennsylvania called PACE. So we are here really to advocate

on behalf of our constituents, consumers who are receiving benefits, and we want make sure things go as smoothly as possible. We have a lot of experience in delivering I think a very good benefit, and we want to share that to make the Medicare benefit better. So thank you.

MR. BARNES: My name is Cliff Barnes. I am a health care attorney in Washington, DC with Epstein, Becker & Green, and I work in Medicaid, in the Medicaid area primarily. Thank you.

MS. RICHARD: Good morning. My name is Sybil Richard. I am the Bureau Chief of Medicaid Pharmacy Services in the State of Florida. Florida had an SPAP program a few years ago. We wrote it into our Pharmacy Plus program, but there is still a smaller benefit that is available where the state does provide some assistance to their beneficiaries in the state.

MS. NAGLIERI: Good morning. My name is Julie Naglieri. I am the Director of the New York EPIC program, which is New York's SPAP program. We are a large drug program for seniors in New York State offering comprehensive, unlimited benefits. So I think my perspective here is obvious, and I welcome and look forward to this opportunity.

MS. HINES: My name is Laurie Hines. I am

the Executive Director of Missouri Senior RX, which is the smaller version of an SPAP in this country. So I am here I hope to speak on behalf the states that have small versions of SPAPs that also bring experience and concern for low income elderly.

MR. CLARK: I am David Clark, Vice President of Pharmacy Services for the Regence Group. We represent Blue Cross Blue Shield plans in multiple states, and we have supported Medicaid and Medicare as well as commercial business and are also currently talking with several states about how to improve their pharmacy --- services to their program participants.

MR. CHASE: I am Jim Chase, Director of Health Care Purchasing with the Minnesota Department of Human Services where I am responsible for the health care provision for our fee-for-service and managed care programs in all of our state public programs. We have a smaller SPAP compared to some of the other states represented here, but we also have a discount card program which we have started to develop but not implemented. We have a manufacturer program where we use manufacturer free drugs through something called RX Connect that we administer. We also have a Canadian drug website for both Minnesotans and state employees, and so I take to heart the comments about trying

to simplify a point of entry for all those people trying to look at all their different options that we have in the state and how could we make that more simple.

DR. REINHARD: Hello. I am Susan Reinhard, and I am from New Jersey. I think we win the prize for bringing the most people from our state here according to Tom Sneddon. I wear two hats. I am co-director of Rutgers Center for State Health Policy, and you will be hearing from my colleagues, Kim Fox and Steve Crystal. I worked early with them on the studies around state pharmaceutical programs, so we hope to share that information with that hat on. I am also Deputy Commissioner of Health and Senior Services in New Jersey where I work with Kathy Mason. We believe we have the most long-standing, most generous state pharmaceutical program in the country. It is coming up on 30 years. We have a little contest with Pennsylvania every year, and you will be hearing Kathy very soon talk about what we are doing. Obviously we care very much about making sure that things are as simple as possible for older adults and that we use our considerable resources that we have been investing for almost 30 years now in a way to wrap around in a sensible way.

MR. SCHUH: I am Marty Schuh with ACS. We manage SPAP programs in a number of states right now. Our

charter here is to help those states transition from Medicaid into Medicare.

MS. HENNEBERRY: Great. Thank you, everyone. Just a reminder to the audience. If you didn't sign in on the public roster outside, please do so, especially if you think you may want to speak at the end of the day.

Formal Presentations

MS. HENNEBERRY: We are going to begin our formal presentations. Believe it or not with this rather disjointed beginning, we are actually ahead of schedule. So we may get a couple of those in before lunchtime, which would be fine. We are going to start with Kimberley Fox, Senior Policy Analyst at the Rutgers Center for State Health Policy in New Jersey, and we have allowed 45 minutes for Kimberly. She is not going to take all that time to speak, because she did want to be sure and leave time at the end for commission members to ask questions, and if we have extra time we will allow members of the audience to ask any questions or to get clarification as well. So, Kimberley, ready?

Presentation by Kimberley Fox

MS. FOX: Thank you. I just want to make sure I have technical support here before I start. There we go. The commission members did get a draft testimony,

written testimony. I actually revised it somewhat and brought another version of it which I hope got out to you this morning. I will talking largely from that testimony, but I decided to also have a presentation on behalf of the public to sort of follow along what my statements were.

I just wanted to open by saying good morning to the commissioners and the chairman and to thank you for allowing me the opportunity to talk to you about the study that we have been doing for the past three years. It is always nice to see your work actually finally have impact and hopefully inform people that are making important decisions.

(Slide.)

As indicated in the testimony, we have for the past three years received support from the Commonwealth Foundation to conduct a study of state pharmacy assistance programs. That study has been lead by my colleague Stephen Crystal who is with me today to help answer any questions you may have; and it has consisted of a longitudinal survey of state pharmacy assistance programs for the past three years, in-depth case studies of eight programs with subsidy programs and also six state discount card programs -- which I won't address necessarily today -- on various program design issues, enrollment and participation rates, and cost

containment strategies. We also conducted telephone interviews this spring, which is most relevant to the commission's work in that we talked to 17 states regarding their Medicare coordination of benefit issues and their experience with the discount card thus far. We have already issued a number of reports, links to which I will make available to the commission staff. We are soon to release two reports. One which I had hoped to have for this meeting, but I think will be available next week or in the next week or so, which is a really comprehensive chart book from the survey that I described which you give you very detailed information on the various state programs and the different designs of them. We are also soon to release a coordination of benefits report which this testimony largely draws from.

(Slide.)

Just as an overview of what I plan to discuss today to assist the commission in its charge to insure a smooth transition and seamless transition for SPAP into the new Medicare drug benefit, I thought we should focus first to describe how the state pharmacy assistance programs compare and contrast with Medicare Part D benefit and the low income subsidies and then to discuss some of the options being considered by states regarding supplementation of Part

D in 2006 and anticipated challenges, and also to talk a little bit about the lessons learned from the existing third-party payment collections that some states have been pursuing and coordination with the Medicare drug discount cards and try to address some preliminary recommendations for Part D from that experience.

(Slide.)

First I will just start with how many states have SPAPs. I have a lovely map up here that is in our chart book and also draws from data from the NCSL as of August, 2003. There are 22 states that offer nearly 1.8-million Medicare beneficiaries state subsidies for prescription drug coverage in 2003. There were also an additional eight states that were not yet operational but had been enacted. The designs of the programs vary considerably across states. I should also mention that most states are funded solely by state-only funds, but six states including Florida, Illinois, Maryland, South Carolina, Wisconsin, and Vermont have some Medicaid waiver, either a pharmacy-plus waiver or an 1115 waiver where they get Medicaid federal match for low income seniors who otherwise would not be eligible for Medicaid. For the purposes of this testimony I have sort of excluded those Medicaid waiver states only because partially we were focused on people's

experience with the discount cards, and the Medicaid waiver states are ineligible and also they are treated slightly differently from the state pharmacy assistance program. So the majority of this testimony will focus on the remaining 17 states that have state-only programs, and I should just clarify the 17th state is Illinois, which also has a state-only program as well as its waiver program.

(Slide.)

Just in terms of comparing SPAPs with the Medicare Part D and low income subsidies, in your pamphlet or in the information that we provided to you in advance there are tables. One table shows you a pretty detailed description. Table one in your handout shows a detailed description of the different state income eligibility requirements and their cost-sharing requirements. These slides just sort of summarize them to some extent. This particular slide I should note is based on 2002 data based on our chart book and your table one is based on 2003, so it is slightly updated. But as you can see, most states have income eligibilities that are higher than 150 percent federal poverty that is going to be in place for the low income subsidies under Part D and with the average income eligibility of around 220 percent. The principal challenge for SPAPs will be addressing prescription drug affordability

for the near poor and those with some assets who are eligible only for basic Part D benefits, which are generally less generous than the SPAP benefits.

(Slide.)

In terms of comparing the general designs, as I said they vary considerably by state. But in general, the basic Part D coverage generally requires more cost sharing than many SPAP programs, and specifically for enrollees who spend less than $5,100 a year on drugs. On the other hand, Medicare Part D low income subsidies generally provide better coverage or equivalent to that provided by the SPAPs. So the challenge for the states is going to be dividing up their population and assessing who falls into those different categories and to determine both what the state savings will be and what people's wraparound benefits will be in their programs.

With no asset test in most states, I believe it is only two states that require assets tests, and so as a result estimating low income subsidy eligibility will be a challenge for states. Excuse me a second. New Jersey is an example. Because they do not collect assets, they have used alternative measures to try to do a proxy estimate of how many people might not be asset-eligible. They actually require income, interest and dividend income on their

applications, and based on that estimate they concluded that approximately 22 percent of the lowest income tier of those below 135 percent of federal poverty and 14 percent of income-eligible persons in the 135 to 150 percent would not or may not meet the asset tests. Other states such as Missouri -- I know Laurie is here -- in their decision or their proposal to do a doughnut-hole plan they had estimated that approximately 10 percent of income-eligible persons would not meet the Medicare asset test.

(Slide.)

In addition to differences in eligibility and cost sharing, the Medicare benefit also may cover fewer drugs than are currently available through SPAPs. The Medicare drug benefit will be administered by private companies and will utilize cost containment methods that most SPAPs are not currently using. For example, while Medicare drug plans are required to cover drugs in each of the drug categories and classes that are not explicitly excluded from the Medicare drug coverage, they are allowed to use closed or restricted formularies that may limit coverage to only two drugs per class or have higher cost sharing for non-preferred, off-formulary drugs. With the exception of a few states that limit to certain conditions, which is in Maine, in Illinois, North Carolina, and

Maryland, most states have open formularies, meaning that enrollees have access to most drugs that have been FDA approved and for which the state has been able to obtain a manufacturer rebate. Thus, depending on the formulary of a specific plan selected, enrollees may no longer have access to certain drugs that are currently covered under their state program. Particularly in some drug classes such as psychiatric drugs, there is some research evidence that many patients and their physicians are hesitant to switch medications in response to formulary changes, even if the out-of-pocket impact is significant. This might lead even individuals that are eligible for Part D benefits to seek help from states. The issue of help with access to off-formulary drugs may become a complex one for states.

In addition, PDPs may have more limited pharmacy networks than SPAPs. While the Medicare benefit has minimum geographic standards for pharmacy coverage that PDPs must meet, it is unlikely that the PDPs in a region will have the same pharmacy coverage that is available in most SPAPs, which generally averages anywhere from 95 to 100 percent of pharmacies in the state. In fact, states have reported during the discount card period that in looking at some of the pharmacy networks within the discount cards that many of them do not -- are much less extensive than those

are that are provided by the state.

(Slide.)

In terms of future plans, we asked states whether they would be continuing coverage in 2006, and based on our interviews in May and June of 2004 most states plan to continue some benefit. Only two states, Kansas and Wyoming, had definitive plans to stop providing prescription drug coverage for Medicare beneficiaries. As should note that Wyoming's program is actually not age-specific, so it will continue its coverage, but for non-Medicare beneficiaries. Minnesota, Indiana, and North Carolina, which target very low income seniors and whose income eligibility is similar or comparable to the low income subsidies under Medicare Part D, were undecided as to their future, but in general the vast majority of states had plans to continue to provide supplemental coverage in some form.

(Slide.)

In terms of what they are considering, I should say that most states in the short term have been primarily concentrating on coordinating with the discount cards that kicked in 2004. There is a lot of coordination to be done there, and so primarily they have been concentrating on that. However, they have considered what -- and they are also planning on looking at what happens in

the discount card period as sort of a prelude for what is likely to happen in Part D and to, hopefully as Dr. McClellan indicated, hopefully have some lessons learned from that experience that can then inform your work and the future Part D design. But the options that states are considering really run the gamut I would say, paying all or a portion of the premiums, wrapping around cost sharing to current state cost sharing levels, providing coverage during the doughnut hole -- which I mentioned Missouri has put forward a proposal which didn't pass the legislature this session, but the program officials are confident that they will revisit it where they will supplement during the doughnut hole period. So that is one state that actually has a formal proposal of a doughnut hole plan available. States are also considering wrapping around formularies and what the consequences would be of not doing so. I should also note that some states, although not many mentioned it, are also trying to figure out what they will do with non-network pharmacies and whether they should wrap around that coverage as well.

(Slide.)

In terms of challenges, general challenges that they anticipate for Part D, I have just laid out a few of them, but enrollment challenges are going to be a big one

for states. Getting SPAPs to voluntarily enroll in Part D plans is going to be difficult, especially since seniors in some states have become very accustomed to their state program and switching over to a Medicare benefit will be difficult. In addition, as I mentioned, gathering asset information to determine eligibility for low income subsidies is going to be difficult for programs that previously have not required that information amongst the senior population, which is generally reticent to provide the information. For SPAPs that are managed by departments other than the Medicaid agency, conducting eligibility determination through Medicaid may be a further deterrent for SPAP enrollees. I am sure you are all aware of Medicaid stigma issues, and in some states they are more pronounced than others; and state pharmacy assistance programs are really concerned that if the eligibility is determined through that entity it may discourage people from enrolling, and they are hoping that the state pharmacy assistance program can be deemed and be allowed to do eligibility determination for the state as well. In addition, once the people are enrolled I think states have identified coordination of benefit challenges. Once people are in the program real-time information sharing with multiple plans is going to be an issue. Point-of-sale duplicate billing and

enforcement of pharmacies, which I will go into in a little more detail with the discount card, and also coordinating sliding-scale premium payments with CMS were some of the issues that states mentioned.

(Slide.)

As Dr. McClellan indicated in his words, he mentioned the importance of learning from the discount card, and I think that was our premise in talking to states in the spring. I just want to give you a sense of within the state pharmacy assistance programs currently approximately anywhere -- well, on average 50 percent of their SPAP enrollees are considered to be income-eligible for the transitional assistance under the discount card program. So states have an interest definitely in getting people enrolled in that program to offset state costs and to bring in federal dollars and also to just insure that people are enrolled in these programs. Based on our aggregation of estimates from program officials in 15 states, approximately 540,000 enrollees are transitional-assistance eligible. I will also refer you to tables two, three, and four in your tables to just look and see what states have done regarding drug discount cards.

(Slide.)

Firstly, most states have not been mandating

enrollment in the discount cards. Only Connecticut, Maine, and Wyoming have actually passed a statute which requires enrollment, and in those states they have only required it of those below 135 percent of federal poverty. The majority of other states were primarily facilitating enrollment by working with a preferred card and/or auto-enrolling their members, but still leaving the benefit voluntary.

(Slide.)

As shown here, more than half of SPAPs are working with their preferred discount card and/or auto-enrolling. As a result of this, approximately 435,000 or 80 percent of SPAP TA eligibles are already in the process of being auto-enrolled into transitional assistance. SPAPs that automatically enroll their TA eligible members into preferred discount cards found this to be a very effective and relatively transparent strategy to enrollees and recommend that a similar strategy be pursued for Part D.

(Slide.)

And this is just graphically demonstrating the number of percent of beneficiaries. I should just indicate here that the "expected to voluntarily enroll" means that the states are hoping they voluntarily enroll. It doesn't mean that that 20 percent will necessarily enroll. It means that basically beneficiaries are receiving

outreach and assistance in terms of informing them of the benefit, but the state isn't doing anything specifically to facilitate enrollment.

(Slide.)

I just want go back one second and say one unique feature of the Connecticut program is that they are auto-enrolling in multiple cards. They are the only state that has elected to do that. The other states have chosen a preferred card sponsor, both to -- because it will help them coordinating benefits. Connecticut has actually partnered a mandate with the auto-enrollment in multiple cards. So even though they can enroll in any card, they must enroll in one card.

(Slide.)

In terms of lessons from the discount card and also third-party collection experience, I should explain that some programs -- while many programs do deny people eligibility for the state pharmacy assistance program if they have other drug coverage, some of them actually do provide coverage for people that have more limited drug coverage. So they have experience with trying to recover third-party payment, and I think there are lessons to be learned for Part D from that experience. As I already indicated, auto-enrollment has been very successful and

transparent to enrollees, and the commission may want to consider encouraging a similar approach for Part D.

I think the second issue of concern for pharmacies is that both in Medicare discount cards and in pursuing third-party liabilities, claims coordination requires duplicate billing by pharmacies. The states are using the third-party liability lines to basically have the pharmacist submit a claim to the discount card first and then bill the balance to the state. It relies on pharmacies to comply, and states in the past with some of the third-party billing activities have not always found the pharmacies to always be cooperative. So as a result, that may also require additional audits and oversight by the state in terms of enforcement, and some states really are hoping that there would be an ability to identify an alternative approach to the duplicate billing approach.

The success of discount cards also has been reliant or will be reliant on the accurate and timely interchange of information with CMS. Early in the process CMS agreed to provide a data file match with states. States submit to them a list of their enrollees to determine who actually gets enrolled in transitional assistance. A lot of states, particularly those that are not working with a preferred card, will use that file extensively to determine

who needs to still be enrolled and also to determine the spend-down, and that information has not yet actually been conveyed. I think the first file match is going to occur in July, but it will be important to watch that process and also to see how well it goes because the centralization of information I think will be critical. Rather than getting the information from all the different discount cards which the states cannot necessarily rely on, they will be able to get one central information source from CMS; and I think the states have said that is critical, but also it is important to monitor how that goes in terms of implementation in the future.

Also states that have pursued third-party recoveries have found that even with strict statutes it is not easy to get information from private insurers, and many of them pay information brokers to collect that information, so that is an additional cost to the state. So in terms of the requirements that you put on the PDPs, they have to be pretty explicit about what states will need to be providing in terms of information should you go with that more decentralized approach rather than going through primarily relying on centralized information from CMS.

(Slide.)

In terms of policy implications for the SPAP

Transition Commission's work, I think the more plans the more difficult it is to coordinate benefits. It sounds simple, but it is true, and I think that administrative hassles can definitely deter the states from providing gap-filling coverage. So coordination of benefits should be designed to minimize crowd out of current state contributions. There is the possibility for states, particularly those with relatively small programs, that they may just choose to get out of the game. Although right now they are not saying that is what they are doing, there is a possibility of that if it becomes extremely administratively complex to manage it. As I indicated earlier, the centralized information sharing through CMS is definitely a plus and would be preferred rather than having to do it on a retail level with all the prescription drug plans available in the state.

Auto-enrollment, again very efficient mode for getting people enrolled, and I think it is where the states really are hoping the experience learned from Part D will drive what happens -- I mean from the discount card will drive what happens in Part D. But I also just want to caution people that there is a need for continued monitoring of the discount card implementation. Although I indicated that 80 percent of SPAP enrollees will be auto-enrolled,

currently only New Jersey and Pennsylvania have people that have actually cards in their hands to receive transitional assistance. While the process has been relatively smooth, there has been blips along the way, and those blips are things that I think are lessons to be learned in terms of going forward. We haven't even gotten to any blips regarding the processing of claims, duplicate billing, and tracking this enrollment and monitoring the spend-down. So I think there are a lot of things to be keeping your eye on as the discount card goes forward.

That concludes my testimony, but I am welcoming any questions and comments you may have. I am going to also potentially ask Steve to come and help me if I need any help, but please ask any questions you would like.

Opened for Questions and Answers

MS. HENNEBERRY: Thank you very much, Kimberley. Any questions or comments from the commission members? Dewey.

DR. GARNER: In looking at that slide on the states with respect to taking the drug card I noticed it looked like over half of them were below 50 percent. There were only two states I saw that showed 100 percent, and none of those two states were in the mandatory three. How do they get 100 percent if they are not mandatory, or does

automatic enrolling mean that you enroll them and that is not mandatory?

MS. FOX: Actually that slide is just telling you that the number of people in the program that are estimated to be eligible, income eligible for -- I think that is the one. Is this the one you are talking about? It should be the percent of SPAP enrollees that are believed to be income eligible. In the case of Kansas and Minnesota, their income eligibility is 135 percent of federal poverty, so 100 percent of their enrollees should be eligible. Although you do raise a good point, that those states are not states that are choosing to auto-enroll, but I actually having spoken to the states I think it is partially because it is a complicated process to auto-enroll and the programs are relatively small, and again those administrative costs. They didn't necessary think it was worth it in terms of the bang for the buck.

MS. HENNEBERRY: Linda.

MS. SCHOFIELD: I also had a question on auto-enrollment, but let me preface that by saying this was a really useful report and I appreciate all the work that went into it. It was very helpful. Two questions about enrollment, I am trying to understand the definition of non-mandatory auto-enrollment. It sort of sounds like auto-

enrollment is fairly mandatory. Do the states give people an option to opt out after they have been auto-enrolled or --

MS. FOX: Yes.

MS. SCHOFIELD: -- to change and that is what you are defining as non-mandatory?

MS. FOX: Yes. Yes, states are required to offer beneficiaries an opt-out, and states have chosen to do that in a manner of different ways and have seen different results as a result of that. New Jersey, you know, everyone sent their enrollees letters and basically said we are going to work with this preferred card. If you don't want to be in this preferred card let us know within a two-week, three-week period I think in generally. States give them around that much time. New Jersey asked them to write a letter, and that seemed to be a considerable deterrent because they had very few opt out. Pennsylvania actually provided them with a form to return, and they got more opt-outs as a result, but the other thing that states have found is that those initial opt-outs haven't always -- they have done follow-up with the people to really try to find out if they mean what they say and they have just found that a lot of people were just totally confused and so ended up -- you know, those opt-outs ended up reversing in the end. But I

should have also said, I didn't refer to it in the presentation, but in your table, I think it is table four, it shows that some states are wrapping around the benefit provided by discount cards and actually, you know, coming up to the their cost sharing. Most states are doing that even -- I think, even if you don't go in the preferred card and you are in another card, they are still providing that. They are just discouraging it because it is much more complicated and difficult to work with all of those plans.

MS. SCHOFIELD: So do you know if there has been any follow-up so that you figure out when people opt into a card, whether it is the preferred card or not? Are they actually using that card, you know, if they have been sort of mandatorily enrolled? Do they understand how to use this thing that they have been involuntarily, although not mandatorily, enrolled in?

MS. FOX: Yes. I don't want to preempt Kathy Mason's presentation, because I know she will talk a little bit about what they have done in New Jersey in that regard, but yes. Basically the beneficiary only has to show the card once essentially to the pharmacy. The pharmacy then becomes the person who is aware that they are on the program and the state will sort of put a flag up on their systems to bill the other payer first and then bill the state.

MS. SCHOFIELD: I mean, my concern here is that this is probably an area where we really want to make sure there is an educational outreach program, because if people are auto-enrolled in something that they don't really understand, they may, you know, have that $600 deduction occurring from their SPAP but not necessarily be understanding how to use their card or sign up at the pharmacy to use it.

MS. FOX: Right. Well, when I talked about smoothness, again I am going to defer to Kathy, but I mean the process of educating beneficiaries is not to be taken lightly, and I think New Jersey has invested a fair amount in additional staffing of their hotlines and everything else and other states have as well just in response to the general confusion on the part of beneficiaries.

MS. SCHOFIELD: And I had one quick question about Connecticut, and I don't know if you want to answer this or Marc, but how do you actually select which plan to auto-enroll people in? Is it sort of just, you know, today is Tuesday so you are in this plan?

MR. RYAN: Do you want me to hit that? Yeah. Basically what we did was, just a couple quick stats, we had originally estimated about 25,000 people would be eligible for the transitional assistance. We are now thinking our

numbers are closer to 22-. Some of this was a good education about exactly, you know, where people fell in the income scale and stuff like that, so it is in that range. So far we have enrolled in the discount card about 18,000 people. We obviously have some more work to do. We had about 13,000 that actually chose to actually enroll, which actually was a pretty good number. We had a pretty fair, pretty good, you know, form we sent out educating people on it. We got out there before even CMS was getting things out because we were worried if there were multiple things out there, so we wanted to hit the ground running working with CMS on that issue; and we only had to really so far enroll about 5,000 people that did not have a choice, and it is really just rotating. We just have our vendor essentially rotate people through the cards. We decided to have multiple cards frankly because the way our SPAP works is it a very open formulary, you know, right now. So the drug discount card, we didn't feel like we were going to get a discount any deeper than our CONNPACE discount already. The discount wasn't an issue for us. It may be in other states, but for us we piggyback off the Medicaid discount and we just figured if somebody wants to have multiple cards, you know, we will just let them enroll in whatever card they feel most comfortable with because we didn't want to buy

that political anxiety as I call it if we did it.

MS. FOX: I would just add to that that all states really have determined that the discount component of the Medicare discount card was not beneficial to them, and they have been focusing pretty much exclusively on that $600 credit.

MS. HENNEBERRY: We have a question over here, and I do want to remind commission members if you could state your name when you ask a question for the sake of the recorders. Nora.

MS. DOWD EISENHOWER: Good morning. Yes. Nora Dowd Eisenhower. Thank you, Kim. That is an excellent report. It is nice to see both you and Steve here working on this issue. It makes me feel better about it. Just a couple of things. I would just like to address a bit the use of the language voluntary and auto-enrollment. Remember, the individuals we are talking about here have been participating in the PACE or PACENET program in Pennsylvania, and we have been paying their cost for some time. For us now to tap into that $600 transitional assistance and use that as the payer of first resort is not I think the typical situation where someone can say, "Oh, look. Here's an array of 20 programs." Well, they are lucky there are only 20 programs to choose from. It is

slightly different, so I think in using voluntary and required and necessary I think we should be a little bit more careful with that language.

The other question I have is we are hoping in Pennsylvania to expand coverage to higher-income individuals with this federal dollars that we draw down, and I didn't see that in your survey of other states, but I did want to mention it. That was an option. Now, that hasn't been achieved, and that will need to be a legislative issue, but that is something that we are considering as time progresses.

MS. FOX: Yes. I would say that Indiana I think in the short term during the discount card period actually did expand its eligibility because of its anticipated savings, but most states -- exactly as you pointed out, it is a legislative issues, and we were talking to program directors. It is a little early on I think, that they just weren't, you know, ready to be out there yet as to how much they are expanding. But certainly states are going to stand to gain a considerable amount to the degree that people fall in those low income subsidy groups, and they will have the opportunity to potentially expand eligibility.

MS. DOWD EISENHOWER: Which is really a bright light for us in the state. I think the other issue,

just a question on the discount card, what we are anticipating in that as time passes drugs will be move on and off various PDLs for the cards and prices will change. I know it is probably too soon to see much of the impact of that, but we are really concerned about that just from the viewpoint of the rest of our older Pennsylvanians who will be buying a discount card, one or two of them. So do you have any sense of that or any sense yet where that is going?

MS. FOX: Well, states are protected somewhat from that formulary issue to the degree that the $600 credit can be used for off-formulary and formulary drugs, so I am not --

MS. DOWD EISENHOWER: I am really thinking about individuals that just -- you know, how is it playing out for individuals that aren't in a state plan or, you know, in those states that they haven't reached them yet with the income level expansion?

MS. FOX: Yes. To be honest, I don't know. I mean, other than anecdotal press reports that said a lot of people are concerned about the constant changing. I think the one thing that is good about Part D, as I read it anyway, is that plans won't be allowed to -- they can only change their formularies annually, and I think that will be much easier anyway for the states in coordinating their

benefits rather than having to deal with a constantly-changing formulary.

MS. DOWD EISENHOWER: Thank you very much.

MS. HENNEBERRY: Additional questions from commission members? Susan.

DR. REINHARD: Thank you, Kim. Great job. I just have I guess a comment and a question for you. The comment I guess get to the auto-enrollment issues and also what Nora just said, and something that we really didn't even think about early on in New Jersey but has come to pass is that those folks that are on the transition, the $600 kinds of folks, they often pay a lower co-pay, so that we have promised we are going to pay -- they will never pay more than $5, which is our current PAAD program. But many times because of the structure of the drug discount program for lower income seniors they are paying $.50, $1, and this is something they are calling us and saying this is great. So there are some benefits. Now once they get past that $600 of course that changes, but it is pretty significant for them.

The second thing, question I have for you, Kim, is right before your presentation you said something about auto-enrollment really is auto-application, and I wondered if you could say something because I thought it was

interesting and the commission members might want to ponder that.

MS. FOX: Right. Actually I forgot to mention it in my presentation. It was actually someone from Connecticut mentioned this to me, is that auto-enrollment technically if you were to use the literal term means that the people would automatically be enrolled in a program because you have already deemed them income-eligible in your existing program. There is still an eligibility determination process that the states have to go through in what we are deeming auto-enrollment. So they described it as auto-application, and that process has taken a bit longer than originally anticipated and that doesn't bode well necessarily for Part D in the future given that Part D will have much more complex eligibility requirements, including asset tests, so that is not a good thing.

MS. HENNEBERRY: Jay.

DR. CURRIE: Yes. Jay Currie. I am wondering in those states where there is voluntary sign-up for these cards is there any trends that you see in what have been effective education strategies? I think a lot of times it comes down to, you know, a one-on-one meeting with somebody and sometimes that is somebody that is supposed to be at the state level and other times it is in the pharmacy.

Are there any strategies that you have seen in those states that are at least a trend that looks like it is more successful than other methods?

MS. FOX: Not so much in the discount cards because they have just started, and actually the states don't even know how they are doing because they haven't yet received that file match from CMS to really see what their -- you know, how many of their enrollees are enrolled in discount cards. But we did do a study of participation rates in the general state pharmacy assistance programs, and it is hard to tie actual, you know, clear ties to higher enrollment to certain outreach strategies. But states have found using the SHIPs to be very successful, going out in community-based organizations, going to churches, going really down to the grassroots to be an effective strategy. Auto-enrollment was being done, by the way, in states, in Minnesota and in New Jersey, of programs of people that are eligible for other programs were being auto-enrolled. That was a very successful strategy. Am I missing any? I can't think of -- what I will also do, by the way, is link -- send the commission a link to our reports, specifically on participation rates in SPAPs, which goes into great detail about different strategies that states have used to get people enrolled in their programs. Which, by the way, take

up in the state pharmacy assistance programs -- of course, many of them have been around for 25 or 30 years, but it is relatively high, which is a good sign that they are actually reaching out to the community. But there are still a number of people who are not -- they are eligible and not enrolled in the state pharmacy assistance programs as well.

MS. HENNEBERRY: Robert and then we will come back to Jim. Go ahead.

MR. POWER: Bob Power. Can you expand on your concept of centralized versus decentralized about know what Part D program someone is in? I think I was assuming that centralization was going to occur, and can you comment on whether CMS is getting ready? Because they obviously need to have already started in order to be ready by January of 2006.

MS. FOX: I might defer to CMS on that to some extent, about their plans for 2006. The data file match was something that was done that came up based on conversations with states and discussions CMS has had with numerous states that it would be beneficial for the states to be able to get that from a central source. I don't know if it is the plan for Part D, but it works well because it is one source of information providing you will all your enrollees, what plans they are enrolled in, when they were

enrolled. So it is actually not that many fields right now, and states probably have other ideas of things that could be added to that file match, but it provides -- also the spend down -- I am sorry, the application data and also if they dis-enroll and the spend down. So it provides very useful information to the states in terms of tracking across all the different plans. I should say it will provide it when it is available.

MS. WATCHORN: Marge Watchorn. I think that is a really good idea, and I think it is something that we are definitely open to exploring. I think just from a practical standpoint a lot of the brain power and manpower on my team anyway has been devoted to, you know, the data match and whatnot for the drug card, so I think that is a really good idea for Part D as well.

MS. HENNEBERRY: Jim, you had your hand up?

MR. CHASE: Yes. Jim Chase with Minnesota. You made comments around the difference between open formularies and formularies in both the drug cards and Part D, and I just want to be clear at least from our state's point of view that it isn't that we think open formularies are good and closed are bad, but there is a coordination issue that I think we have to deal with when people are transitioning. So your comments around concerns that people

may be on particular drugs from our point of view isn't one that we want to keep them there forever, but there may need to be some transition. Because formularies are a way for us to help control the cost, which I think is one of the objectives that we are going to have to have here as well, is how do we be sure to maintain certain cost strategies that we have. I think the reason why we have had open formularies in many states has more to do with the rebate structures that we have been stuck with, if I can put it that way, than it is as a policy issue that we think it is inappropriate to have a formulary.

MS. FOX: I would only add that I think that states are concerned about the differences in formularies across plans and coordinating with them, and also the potential consequences. Some states are concerned about consequences of drugs that are not going to be included in the formularies.

MS. HENNEBERRY: Barbara.

MS. EDWARDS: Barb Edwards. Kimberley, can you say a little bit more about you mentioned that some states have not done an auto-enrollment. Frankly I thought it was very helpful that it is auto-eligibility or application. Can you say more about what those administrative requirements have been that would have caused

some states to not go down this path and whether those challenges go away with Part D or change with Part D?

MS. FOX: Well, some of the states it was a timing issue. For example, it requires that the state be an authorized representative on behalf of the enrollee, and some states had that authority and some states did not. The states that did not have that authority had to pass something statutorily. Some states were past their legislative sessions and were not able to do that, and I know that was an issue in Missouri, so they didn't get to take advantage of the auto-enrollment opportunity just because of the fact that their legislature was past its session. I also think that -- I am forgetting what the first part of your question was. That was one issue. Also some states don't currently work with a preferred -- a PBM or some private entity that had a Medicare endorsement for a drug card, so they would have to potentially RFP, put out an RFP to identify one, and RFPs can be an extensive and timely process. Although in New Jersey they did it actually pretty rapidly and were pretty successful.

MS. HENNEBERRY: Martin.

MR. SCHUH: Could you comment a little bit about the difference between the drug card and a PDP as far as auto-enrollment goes or automatic application, what have

you, because the drug card seems to be a limited kind of thing, 18 months. The PDP sounds like if you get stuck in a bad PDP, if you have a choice, the implications are far greater than they would be on a bad enrollment in a drug card. Can you speak to that a little bit?

MS. FOX: Well, to the degree that states wrap around the coverage to their existing coverage, the enrollee may not see that. It could be potentially a problem for the states in terms of the level of money that they receive that, but I don't think it will necessarily be something that the enrollees would be aware of. I mean, the Part D auto-enrollment I think that the -- it is still up in the air obviously. The discount card, it was increment -- I know you know this, because you were talking about it before. It was an incremental decision-making process essentially that states came up with in order to really get people enrolled in that transitional assistance. I think it is a model that could be modified for Part D. I think there needs to be, you know, details would need to be worked out, but the fact is that right now states are working with one preferred plan, which could be a preferred drug plan as opposed to a preferred discount card. In fact, frankly many of the discount cards, you know, are anticipating that this is a potential lead-in to Part D, and so I think that is

partially why they are interested in getting into the discount card game to start. So they are seeing this as a sort of transition to the future.

MR. SCHUH: Well, certainly, and I think the logistical hurdle that was overcome by the drug card enrollment I think will lend itself to hopefully a smoother transition for PDPs if in fact it comes down to that. Last question is if there is more than one PDP in a region, how will the state contemplate picking a PDP if auto-application or auto-enrollment was the issue? Would they RFP that, or would they select based on a profile of the bene? Give me some thoughts on that, if you wouldn't mind.

MS. FOX: I have to say this is something the states aren't even there yet on, but I imagine that they would follow a similar process and probably either use their existing contractor or do an RFP.

MS. HENNEBERRY: Are there any states folks who want to comment? Marc?

MR. RYAN: Yes. I think to me that is a very important question for, you know, the SPAP states because with lead times with competitive procurement and things of that nature and depending on the flexibility of that CMS will give in terms of choosing one or more. I mean, it was an easy choice for us to make to allow any discount card in

our case, but when you get into the full drug plan rollout we really need to know very soon. You know, we probably need a year lead time at least in our system to actually understand what flexibility we get from CMS about choosing a plan or two and then actually procuring it and working with that vendor to make sure the integration is there. So to me, that is probably one of the most important things we do here in my opinion.

MS. HENNEBERRY: Donna, and I do want to clarify. It is my understanding that enrollment will actually begin in November of 2005, although the benefit doesn't begin until January. So is that your understanding of the law as well? Okay. Donna.

DR. BOSWELL: This is Donna Boswell. I guess I am looking for some clarification. I wasn't aware if CMS had taken a position on whether or not the coordination for Part D can be just with one or two plans, or whether the states are -- the SPAPs are going to have to coordinate with all of them, which is why I was very encouraged about Connecticut's potential success in doing that. Has there been any guidance on that, or is that one of the issues that we will be looking at?

MS. WATCHORN: Yes. I am not aware. I am looking at my team leader. I am not aware of any decision

that has been made on that.

MS. FOX: I would just -- oh, go ahead.

MS. DUZOR: (Away from mic.) Well, let me just add that there is a provision in the statute and in how we interpret it I am sure there is flexibility, but it is sort of an anti-discrimination provision for SPAPs when dealing with PDPs. So I think that the world is a bit different in Part D than it is with the discount card.

MS. FOX: I want to address that, because I have looked at I think the states are a little bit confused by two elements of the law. One is that it does say that SPAPs can't discriminate based on eligibility or enrollment in a specific card on the one hand. On the other hand, it also does allow for a lump sum payment to be done with a, word singular, preferred drug plan which would imply that you could work with one. Also there is also the shared emblem issue, and that implies that it would be one card with one emblem. So I think there is a little confusion on the part of states, but I would also add that technically under the current discount card model the states would comply with the eligibility determination issue because in fact states are providing wraparound benefits for all plans. They are just preferring one plan and trying to get people enrolled in one plan, so it is not that they are

discriminating to people based on the enrollment in the plan.

MS. HENNEBERRY: Donna, did you have a follow-up before we move on to Bob?

DR. BOSWELL: I had a question on a slightly different subject.

MS. HENNEBERRY: Okay. Then we will go Bob, then Donna and then Julie.

MR. POWER: This is Bob Power. I just wanted to also note that we private health plans -- oh, by the way, we have begun to use the jargon AB and ABD, and if somebody has better jargon let me know. But we are going to be an ABD carrier, and so when you think about a multiplicity of people involved remember us, too.

MS. EDWARDS: ABD stands for? I am sorry.

MS. HENNEBERRY: Yes. Would you tell the audience what ABD stands for, Bob?

MR. POWER: Oh, excuse me. AB health plan is covering parts A and B of Medicare only, and ABD health plan is an integrated health plan where the health plan itself is also providing the drug portion. You can imagine how we feel about the potential of having to work with who knows how many D-only plans when we want to coordinate the medical care with the drug coverage, so again -- but my

point in this instance was just that when you think about a multiplicity of players remember that we are there, too.

MS. HENNEBERRY: Okay. Thank you. Donna and then Julie.

DR. BOSWELL: Yes. It is Donna Boswell. I had a follow-up question on the -- relating to what we talked about earlier about the differences between Part D and the drug cards, and it occurs to me that in your discussion of the coordination of benefits third-party liability strategy that maybe that is also something that is sort of unique to the card situation where really the state is still the main benefit plan that the patient has, that really the primary benefit of the Medicare card is the $600 financial assistance to sort of go toward the state as still the big player. But that sort of gets reversed under Part D, and I wonder if you had in any of your conversations with the state sort of explored the differences? Because once the patient enrolls in either an ABD plan or a PDP that plan is going to be sort of their primary payer, the person managing their benefits, and then the state will be wrapping around, whereas right now it is really the state that is the benefit provider.

MS. FOX: I don't know if agree with that on the discount card, but I definitely don't agree with it on

third-party coordination. On third-party coordination the state is the payer of last resort, and they are billing the primary insurer first, and so it is very similar to Part D. The problem is that it often happens, has happened retrospectively as opposed to prospectively, and that is largely because states don't have the information available to really know who is covered.

DR. BOSWELL: Right, and I guess I am agreeing with you, but it seems like a really cumbersome system to commit to going into this rather than starting to look for a much more seamless, less administratively-complicated thing with the duplicate billing.

MS. FOX: Oh, I agree with you on that. I think the states also, I mean, they are coming up with a solution that is the most immediate so that they can accomplish what they need to accomplish. I don't think that they think that this would be the best design.

MS. HENNEBERRY: Okay. Julie and then Jim.

MS. NAGLIERI: Julie Naglieri. I just wanted to go back a little bit and make a point when talking about working with one preferred card or plan versus working with multiple ones. In New York we chose for the discount card to work with one preferred plan. It was convenient, and we were able to auto-enroll and that is going to work out well.

But a major difference between the discount and drug benefit is that $600 transitional assistance which we are working with does not depend on a formulary. There is no formulary issues, and with the Part D benefit we are going to have formulary issues. So I am very anxious to see what the drug plans are going to be offering out there in terms of formularies, and that is going to be a big factor in deciding whether or not to work with one preferred plan or not, but I do think states need that flexibility.

MS. FOX: I would just say I agree that it is almost a tangential issue somewhat, although states that did request for proposals did consider that, you know, what the plan's formulary was in making its decision. They wanted to get a formulary that was most in line with their programs. I mean, it wasn't necessarily easy to do, and they did look at the rebates being achieved through those, so it was a consideration. But you are right, it is totally different. It will be a totally different thing in 2006.

MS. HENNEBERRY: Okay. Jim, and then we will go to Linda and then Marc.

MR. CHASE: Jim Chase. If I can kind of circle back to a couple of the points. One is around states making the choice of who would be a preferred plan. I think we need to keep in mind the medical side of that equation

and not just be focused on the pharmacy, because I think we are going to have an interest in integrating care as much as we can. I wish I had asked the question earlier of Dr. McClellan, but in the charge for us it mentions sort of the principles of the MMA as being something we are looking for; and whether integration is part of the principles, even though there are separate PDPs set up, there is clearly some advantages of advantage plans and whether that is an intention. The reason why I bring that up is to also circle back to the CMS question around would we be obligated in any way to not be preferential to certain PDPs under Part D. I would encourage CMS to not restrict states in that, especially given that it is state money that is funding that. So for the federal government to step in and provide direction about what states should do with their own money I think is a bad policy, not only from a sort of state financing question, but also from an integration of care question. I think we are going to want to prefer plans that integrate the care between pharmacy and other services, and we need the flexibility to be able to do that.

MS. HENNEBERRY: Linda then Marc.

MS. SCHOFIELD: Yes. I also just want to go back on this auto-enrollment issue. Having run both public and private sector health plan in my experience 80 percent

of the people that you send mail to never read it, and if they do they don't understand it. So I am not opposed to auto-enrollment, but I am very concerned about how to translate that in the future into a process that is going to be effective given some of the comments other people have made about if you auto-enroll into a PDP you have got a lot of impact on things like MA-PDs where people are required to use that single plan. You know, there are formulary considerations and network considerations that if someone gets auto-enrolled into a plan that doesn't have their drug covered or doesn't have their pharmacy included, they don't read their mail, and then they don't opt out of that plan. They are locked in for one year into a plan that doesn't cover their needs. So I think it is something we have to be very concerned about. How do we do an educational outreach plan if a state chooses to auto-enroll that is going to be really effective in making sure that people understand what their choices are and what they are giving up by inaction, and I am almost concerned that you can never hit 100 percent of people because in my experience you never get 100 percent of individuals you send mail to to really understand what it is that they are receiving. So I think it would be really helpful to understand from those states that have done auto-enrollment already. Have you surveyed pharmacies to see how

many people are showing up at the pharmacy with their SPAP card and only there discovering that, oh, gee, you are auto-enrolled somewhere so your SPAP isn't paying? "Do you have your discount as well?" "Discount card? Gee, I didn't know I had one." That is because you didn't open your mail. So, I mean, I think we need to understand how often that happens and what you have been able to do to successfully overcome that kind of problem.

MS. HENNEBERRY: I think we will hear from New Jersey and from some of the other states, too, that it takes multiple different approaches. I mean, we have learned lots of lessons from other public insurance programs about the variety of ways that you have to educate people, and mail alone certainly isn't effective in most cases. Kimberley, did you want to comment on that?

MS. FOX: Yes. I just wanted to comment. Yes. Linda, I just wanted to let you know that in the discount card program the states are coordinating with the Medicare advantage plans that have exclusive cards, and in the case of Pennsylvania for example they are actually working, doing the auto-enrollment on behalf of those entities. So the states have been aware. I mean, some states have more managed care than others, and some states have managed care that doesn't have prescription plans, but

those that do have definitely been coordinating with those plans and separating out the people from their auto-enrollment process that should be auto-enrolled in those other cards.

MS. HENNEBERRY: We have a question from Marc, but before we go to that, I assume -- is Kathleen behind you, Kimberley? She is sitting behind you?

MS. FOX: Yes.

MS. HENNEBERRY: I just want to make sure it is okay with you, Kathleen, that we do your presentation before lunch. Are you prepared to do that?

MS. MASON: That is fine.

MS. HENNEBERRY: Okay. All right, Marc.

MR. RYAN: Yes. Marc Ryan, Connecticut. I guess to go back to a point I made and I am going to reflect on something James just said recently. Our system is run in essentially a fee-for-service environment. So whether we migrate from our relatively open formulary more toward a more restricted formulary probably is not as much of an issue as the administrative burden of having to probably expend dollars and have to integrated with a number of different providers. Again, relatively easy with the discount card, much more difficult with the full rollout of ‘06. So I guess a question that I know can’t be answered

now, but we would really be interested in knowing when CMS, whether it is during the regulations or beforehand, is going to be able to give guidance on the issue of the anti-discrimination language versus the other language that tends to lead you to believe that you might have the ability to essentially restrict through a procurement process integration with the state plan.

To James' point, and I guess I will take the opposite tack here, although selfishly a state would probably like to have just one or two cards to work with, knowing that there is a very important federal policy of moving toward folks from fee-for-service part A and B to part C, I think it is important that CMS also for states to not restrict it just to one or so cards. They should mandate, you know, coordination with Medicare advantage plans out there because we know that by the end of the decade that real impetus, whether it is through premium increases in B or elsewhere, is really going to moving a part C type of things well down the road. So it is sort of a flip side of the other argument.

MS. HENNEBERRY: Any other questions from commission members? Yes, Susan.

DR. REINHARD: I think that Kim has responded. It is something you said, Linda, but I think we

have to keep remembering, and I know Kim has mentioned it once. When you say the beneficiary opens up their envelope and then the get to the drug store and it is like, you know, "How does this affect me, and maybe they signed me up in the wrong one." You have to remember that the bigger programs totally wrap around. It is completely irrelevant basically, which plan.

MS. SCHOFIELD: ---. (Away from mic.)

DR. REINHARD: Pardon me?

MS. SCHOFIELD: They may now, but they don't have to in the future.

DR. REINHARD: Well, if states are going to totally wrap around the Part D it will be the same thing. That would be the goal, that the world from a PAAD beneficiary's perspective does not change. They get what they got. They always got it. They are always going to get it. If anything, what has happened to us is they pay less of a co-pay in many cases, but it really is irrelevant which plan in a sense they get, and I think Kim made this point. It is much more relevant to the state on who they are working with and, you know, what is on the formulary and do we make this as seamless as possible, how to lessen the burden for the pharmacist which has to deal with it. So I just want to keep putting it out there that at least that is

our perspective, but these are big programs.

MS. SCHOFIELD: Let me just ask you something.

MS. HENNEBERRY: Oh, go ahead.

MS. SCHOFIELD: I just want to make sure I understand your comment, because I could be wrong. But as I understood something I read, some of the states have basically set up their systems to not pay the first $600 when someone has a discount card. So if someone didn't actually show up at the pharmacy with their discount card I am assuming their SPAP card wouldn't pay it either. You wouldn't wrap around.

DR. REINHARD: I think Kathy -- I can't see you, Kathy, but I don't want to keep -- because I think she is going to explain how this is going. Kathy?

MS. MASON: Yes.

DR. REINHARD: Yes. So you will get more details.

MS. FOX: It depends on the state. Some states wrap to the current cost sharing. Some states, like Pennsylvania I think is one of them, they pay the cost sharing. It is because the discount card requires that five to 10 percent co-pay that many states have decided to step in, and so they do pay a part of a claim, so there are

differences across states. I would just say that Susan's comments definitely are geared towards states that are comprehensive and that plan to wrap around their benefits to their current benefit structure. There are states that have much more limited benefit structures. I mean, the Missouri plan for example to just cover the doughnut hole, the selection of the plan will make an important difference because what is on formulary or off formulary will affect what is counting toward their true out-of-pocket cost and the speed at which they can get to that catastrophic limit. So it does certainly vary by state.

MS. HENNEBERRY: Okay. Well, Kimberley, thank you so much. Thanks for being flexible with our schedule and taking some extra time. We really appreciate that.

MS. FOX: Thank you.

(Applause.)

MS. HENNEBERRY: We are just going to move right into the next presentation since we are a little ahead of schedule. Our next presenter is Kathleen Mason, the assistant commissioner from the New Jersey Department of Health and Senior Services, and we are going to have her come up and get started and then we will plan to break for lunch at 12:15 as the schedule and agenda reflects.

Presentation by Kathleen Mason

MS. MASON: Thank you for the opportunity to present today on our experience in New Jersey with coordinating our state pharmaceutical assistance program with the Medicare discount card. My name is Kathleen Mason and I am Assistant Commissioner in the Department.

(Slide.)

The PAAD program, Pharmaceutical Assistance to the Aged and Disabled, and the Senior Gold program are both completely state funded. We receive some casino revenue funds and the rest is supplemented with general revenues. PAAD we like to claim is the oldest state-funded prescription program in the country. It is 29 years old, established in 1975. An expansion of the program called Senior Gold was implemented in 2001.

(Slide.)

We have 191,000, approximately 191,000, enrollees in PAAD and through the expansion another 29,000 people are covered. The benefits in 2003 before rebates and recovery, so this would be the benefit to our beneficiaries, came to about $506-million in 2003 for PAAD and another $18-million for our expansion in Senior Gold. Because of the extensive benefit provided where an average-aged beneficiary receives about $2,680 benefits in a year versus a disabled

beneficiary receiving almost $4,800 a year, our benefit is considered the most popular senior benefit in the state. Also a lot of agencies have looked to our experience in working with the disabled population. As you know, the cost for the disabled beneficiaries are significantly higher than the senior beneficiaries, and a lot of other states have been monitoring that in making decisions about covering the disabled population. Because of the nature of their benefits, costs are always considerably higher, almost twice as much for our disabled population.

(Slide.)

In order to be eligible you have to be a resident of New Jersey for at least 30 days, meet our income limits of $20,437 if single and $25,058 for a married couple. Our income limits do increase each year by the amount of the Social Security cost of living increase, so every January our income limits go up. As I said, we cover both seniors over 65 years of age and those receiving Social Security disability benefits. These are Title II disability benefits, so the people are eligible for Medicare after two years of receiving disability. So in general almost everyone on our program is also eligible for Medicare. The Senior Gold income limits are $10,000 over the PAAD income limits. Therefore, they automatically increase each

January. When the PAAD income limits the Senior Gold income limits are bumped up also to be $10,000 higher.

(Slide.)

The beneficiary pays a $5 co-payment on PAAD. Basically we cover all prescription drugs, insulin, insulin syringes and needles, diabetic testing materials. We cover any prescription medication where the manufacturer agrees to provide a rebate to the state. Basically it is every drug prescribed. On the Senior Gold program since there is a higher income eligibility determination for the Senior Gold population that group also contributes more in co-payments. They pay a $15 co-payment plus 50 percent of the remaining cost of the benefit. That is until they reach an out-of-pocket cost cap of $2,000 for single and $3,000 for married. After they reach the out-of-pocket cap they pay only $15 for each prescription for the remainder of the year. I want to clarify that is an out-of-pocket cap. That is not a benefit cap. There is no benefit cap on either PAAD or Senior Gold. The cap is only on the co-payment structure for the beneficiaries.

(Slide.)

Because of the extensive benefits provided through PAAD, we -- as Kim said, I think our experience was similar to those of other states -- found that for the

population on PAAD that is not eligible for the $600 transitional assistance the benefit under the regular discount card program would not make it worthwhile for most of beneficiaries to participate in a regular discount card. The $30 enrollment fee and the discounts of 10 to 25 percent of course would not be beneficial for our population other than those eligible for transitional assistance.

(Slide.)

We therefore focused all our energy on the population eligible for the $600. Actually in New Jersey the majority of the population do not qualify for TA. The whole Senior Gold population has income over 135 percent of poverty. It wasn't worth them enrolling in a discount card. 110,000 on PAAD also have income over 135 percent of poverty and were not eligible for transitional assistance. So we focused our attention on about 81,000 people that we have that are eligible for the TA; and, as Kim explained in her presentation, we are also paying the co-payment under Medicare Part D on transitional assistance beneficiaries. They pay a five or 10 percent co-payment on the Medicare discount card. New Jersey is paying all costs over the $5 co-payment for our beneficiaries, so we are wrapping around the discount card.

(Slide.)

We sent letters to every beneficiary on our program. The first letter we sent in March was a letter to do nothing, and a lot of people here have heard me say in the past the first letter that we sent when we told people to do nothing the next morning we received 2,000 calls on our hotline saying, "Are you saying I do nothing?" We were explaining to them that at that point we were still investigating what was going to be happening with the discount cards. We were receiving a lot of calls from beneficiaries saying, "What does this mean to me?" As I said, the PAAD program is the most popular program in the state. The beneficiaries were terribly anxious about losing any benefit as a result of this, and in response to calls from our hotline we initially said sit tight, let us look into this further, and we will get back to you.

We then sent a second letter at the point that we were told that were eligible to automatically enroll our beneficiaries. We sent a second letter to all our beneficiaries. The population over the transitional assistance limits got a letter saying that after reviewing the benefits it would not appear to be worthwhile for you to enroll in the discount card. If you did that would be voluntary on your part. There was a separate letter that was sent to our TA beneficiaries which gave them the option

of opting out of automatic enrollment if they did not choose to participate. Those letters are available on our Department's website if anyone would like to see the actual language that we used in all letters. They are up on our website in the Department of Health and Senior Services.

Right at the point that we were getting ready to send the letters out and were notified that we could automatically enroll we had already decided that we would need to do an RFP in New Jersey to pick which sponsor would be our preferred provider. Our claims are processed by Unisys. Unisys is not a Medicare-endorsed discount card, so it was not an easy decision of who would be our preferred sponsor. We could not just go with the claims processor as other states did. We did a very expedited RFP process. We worked with our purchasing bureau. We followed all the purchasing property rules. But since there were 21 Medicare-endorsed discount card sponsors operating in New Jersey, we could through purchasing rules do what is called an expedited RFP. Because it was going to a limited scope of vendors, there were only 21 Medicare-endorsed sponsors in New Jersey, we sent the RFP directly to those. So we waited for CMS to announce their endorsement of the sponsors in New Jersey and sent the RFP directly to all those sponsors. Six of them returned RFP proposals back to us, and the

evaluation committee awarded the bid to Medco preferred discount card primarily on the extent of their pharmacy network. We were quite concerned that our beneficiaries would not have access problems, and on price and on their ability to coordinate benefits with us.

So beneficiaries got a letter saying they were going to be automatically enrolled unless they sent us a letter indicated that the wanted to opt out of automatic enrollment; 350 wrote back letters opting out, and as Kim said, even those letters we found in many cases people -- they would just say, "Never mind. I will just keep my PAAD. Thank you very much. We like PAAD. I really don't need to make any changes. That's all there is to it." So we have been working with people one-on-one to explain that they weren't going to lose any benefits, but actually the 350 we were happy with, were the only ones that opted out.

(Slide.)

Doing this automatic enrollment process we have learned some lessons that we wanted to share today. One of the issues that we worked with CMS closely with was after we already had gone through the process of getting ready to do the automatic enrollment we found that the discount card sponsors were obligated under CMS rules to send a welcome kit to their beneficiaries, and the welcome

kit included a discount price list. Now as I said, we had spent months explaining to our beneficiaries "Don't worry, you are not going to lose any benefits if you enroll in the Medicaid discount card. Nothing is going to change for you. You are only going to pay at most the $5 co-payment." Now if the discount card sponsor then were to send the standard welcome kit required by CMS, that would include a discount price list. Our beneficiaries would have been very upset because they would have believed that seeing a 12-page brochure in with the welcome kit that showed prices for their drugs they would have been sure that somehow we weren't leading them the right way, that automatic enrollment process still was going to cost them money, which we had spent months trying to reinforce this will not happen.

Luckily with working with many of the people from CMS in this room, we did run and explain that problem, and they agreed to allow us to revise the welcome kit and actually eliminate the welcome kit in many ways and just send a letter to our beneficiaries saying "Here is your new card." But that also is a lesson that I think we need to remember for the 2006 program.

Again, if you expect from a PAAD beneficiary's standpoint in January of 2006 we are going to

be telling people "Don’t worry. PAAD is going to wrap around all your benefits. You are not going to have any change. You are not going to have to pay a premium. You are not going to have to pay a deductible. We are going to cover your drugs through the doughnut hole." If the PDPs are at the same time sending literature to those beneficiaries saying, "Well, this is what our program has. Our program you pay a $35 premium," and there is the co-insurance amounts and things like that, we are going to totally once again confuse our beneficiaries. We would have to keep sending information from the state level saying, "No. We are going to pay the premium. We are going to pay the deductible. We are going to pay the doughnut hole," and they are going to be getting bombarded with information from the PDPs saying "This is our plan. This is what we have to offer."

So again I think this commission and the SPAP directors have to be aware that this welcome kit lesson learned does apply in 2006 because again the standard benefit information that would be provided by PDPs will be confusing and contradictory to what SPAPs are trying to educate our beneficiaries about. So anything that this commission can do to try to address that early on I would certainly appreciate.

But we also want to say that we are quite happy to report that the system is working. People have cards. We are saving money and beneficiaries are saving money.

I had talked initially about 81,000 people eligible for automatic enrollment. We did want to do some special handling of the long-term care population. If you recall, there were special discount card sponsors just for the long-term care population, and at the point we were hurrying to get this implemented I didn't want to automatically enroll our long-term care population in the Medco preferred discount card if there was a possibility that some of those long-term care pharmacies with their specific claims processing issues would instead be working in one of the long-term care discount card specialty programs. So we pulled them out. As it turns out we probably didn't have to pull them out of automatic enrollment, and we will be automatically enrolling in Medco because most of the long-term care pharmacies in New Jersey are actually enrolling in Medco. But as I said, we were anticipating that as a potential problem, so we pulled them out right away out of the mix. We also pulled out anybody that had other insurance because you cannot be eligible for transitional assistance if you have other insurance, and we pulled out people in the Medicare Plus Choice plans.

So we wound up with 77,000 people that we were moving to automatically enroll. We sent the file up to CMS on May 21st with 77,000 beneficiaries on it; and, as I said, 68,000 are now enrolled. The first 21,000 made it through May 28th, before the June 1st deadline. Those we found were the people on PAAD who were also SLMB beneficiaries, specified low income Medicare beneficiary. They did not need to go though the extra income checks at CMS because they were already receiving federal benefits that included an eligibility determination, so they sailed right through. They got through before June 1st, and then there were some claims pended at CMS. The 47,000 that were initially pended for income verification and matches against IRS did make it through June 4th, and I can report that as of June 26th we had 14,669 claims processed through Medco and the state of New Jersey was already saving about $1.2-million. In one week alone, the week ending June 26th, we saved $900,000 in that week alone, and we know even next -- the report that will be coming in any day -- in fact I was hoping to get the numbers before I presented. We expect that number to keep increasing as you figure June 4th was when that last group of 47,000 first got their card. They are just hitting the pharmacies now and using the coordinated card.

As I said again, though most of them went through and things are working relatively well and we are quite happy, there were some little glitches, as to be expected. We had about 6,800 errors reject when they were processed through Medco to CMS. One of the problems and the rejections, most of those 6,800 rejections, were a mismatch where we tried to match the PAAD Social Security number and the Medicare number that we had on our application with the CMS number. It was probably key punch errors. That is easy to happen. The majority of them were just mismatch in the Social Security number of Medicare eligibility numbers, and we are just going to resubmit them. We are correcting them and resubmitting.

But one of the problems was that 1,100 of them were Medicaid disenrollments. As I said, we were one of the first files to make it through CMS on May 28th, and 1,100 were approved initially as eligible, but two days later -- that was Memorial Day weekend when our claims were processed. Our file was accepted on the Friday before Memorial Day. We ran and had those cards printed up and mailed out because we wanted to get out there for June 1st. What happened though on the Sunday of Memorial Day weekend is the file was then matched against Medicaid records, and after the cards were already issued CMS disenrolled 1,100

people as being matching against Medicaid files. That presents a problem because those 1,100 people are out there with a card because they were approved and we issued the card and then later found that they hit a match on Medicaid. It was our understanding that once a person had a discount card they could keep the discount card even if they became Medicaid eligible. So we understood that you could be denied eligibility from matching against the Medicaid file, but we did not understand that you could be disenrolled; that once you had the card, you were supposed to be able to keep the card. The problem there seems to be timing of matching the files. It was a new program. It was a rush to get things done for June 1st and it was Memorial Day weekend when the file was initially approved, and then later the Medicaid match was done and they were disenrolled. That is an outstanding issue. What we did was take the edit off our system that would require the beneficiary -- the pharmacy to bill the discount card first and then bill PAAD, because we didn't want to have this population who have incomes so low have problems with actually picking up their prescriptions at the pharmacy. The problem with that is then the state is not realizing the savings of course and PAAD is paying full, but we have that as outstanding issue with CMS.

There is also a similar problem that we had

with only 150 people where the CMS match indicated that the person was on a managed care exclusive card. We were lucky in New Jersey, and Tom and Julie can tell you. We talk a couple times a week on this enrollment process, and in Pennsylvania and New York they had a lot of people eligible for managed care exclusive cards. We lucked out in New Jersey because there is only one exclusive card sponsor operating in one county in New Jersey, so it wasn't as big of an issue for us. So we, as I said, excluded those names before we did the automatic enrollment process. However, CMS rejected 150 cases as being in a managed care exclusive card, and actually it wasn't one in New Jersey. What we did was indicate on our claims processing system that these beneficiaries should use their other exclusive card first. But we are getting calls from our beneficiaries saying "We don't know what you are talking about. We are not on managed care. We don't have another discount card," and we have to rely on CMS information because CMS is the one who told us these people do have an exclusive card through another plan.

The file match that Kim was talking about earlier will help states in this situation. Unfortunately this file match isn't ready yet, because if we had the file match we would be able to say to the beneficiary, "Well, CMS

reports that you have a discount card ABC." We don't have that now. All we have is a rejection, and we don't even know what card the person supposedly has. So those 150 cases, CMS has been very helpful. They took the actual list of names for us. They are looking them up for us and getting back to researching for us what plan do these people have that some of them don't even know about.

On both the 1,100 Medicaid disenrollments and the 150 managed care rejections we are getting calls from our beneficiaries saying that the information that CMS has isn't correct, and when we looked up some of the Medicaid files we found that actually people have been terminated from Medicaid. I am sure you are all aware of the transient population in and out of Medicaid. We frequently have people who are on Medicaid one month and then fall into PAAD and vice versa, so that is always going to be a group of people who are going to fall between the SPAPs and Medicaid eligibility. Again, I see it as another lesson learned that we could apply to 2006, where we are going to have to be aware that this is going to happen. We are going to need to have very updated file matches. We can't rely on a Medicaid eligibility file that is three months old because information changes. These beneficiaries move in and out. So again for this commission, one of the things that we

need, certainly these types of file matches will need to take place, but we need to make sure that the information is very accurate and very timely.

I would also like to thank CMS, because as a result of all these file matches we have also identified some of our beneficiaries did not tell us that they lived in another state, and in fact 60 people we found out live mostly in Puerto Rico. We are enjoying true cost avoidance with these people because they are going to be terminated from our program. As a result of some of these file matches we found people in Medicaid in another state and we found people in Puerto Rico where they probably a residence of a temporary residence in New Jersey or they have a family member in New Jersey, but they have another residence which they are telling Social Security is their permanent residence. So that was some more money, more cost avoidance that we found as a result of file matches is that we identified some people that really shouldn't even be on PAAD. We are going to use Social Security as the final determination of where is your principal place of residence, which is required.

So this lesson learned goes back to what Kim was talking about, the difference between auto-enrollment

versus auto-application. If it was automatic enrollment, all 77,000 people that we submitted on May 21st would have had their card on May 22nd. But it is really an auto-application, because there are these different additional checks and balances done after the file gets to CMS; and that is what I think of as being relatively minor glitches in the system, and most of them are through. Most of them have cards.

(Slide.)

Here is where we can talk about how the claim actually works at the pharmacy. The pharmacist is required to submit the claim to the Medco preferred discount card first and then bill PAAD for any costs over the $5 co-payment. Once we got the file back from CMS that showed that the people had made it through the process of full automatic enrollment, we process a transaction on our point-of-sale system to indicate to the pharmacy that the beneficiary has this other coverage. As Kim said, we are using our third-party liability field on our pharmacy claims processing system, so that claim is actually denied to the pharmacy and he gets a message to bill Medco first before submitting the bill to us. Also we use the same process where we were notified that these people had an exclusive card through a managed card entity. We again put an

indicator on our third-party liability field on the point-of-sale for the pharmacy to indicate to bill the other plan first.

There was a question earlier about what happens if the beneficiary shows up at the pharmacy and doesn't have the other card. We did anticipate that, and our hotlines have all the information that a pharmacy would need to process a claim through Medco, so if the beneficiary -- the beneficiaries are going to call us. One thing we found, that no matter what we send, who we send, whose issue it is, they have been calling us for 29 years. They are going to call the PAAD hotline, so we have our hotline. Operators have the eligibility information for our beneficiaries online and they also have the information necessary to give the pharmacy over the phone to process the claim to Medco, so we do not have to send our beneficiaries back home to pick up the card. We can tell them right over the phone.

As a result of all this work, we expect to save $90-million in this fiscal year. That is taking approximately 80,000 people times $1,200, because we are anticipating saving the $600 now and the additional $600 in January. So for New Jersey state fiscal year we are anticipating $1,200 times about 80,000 people, or

$90-million. I believe we are going to get that; because besides the $600 benefit, we also are hoping to also benefit from some of the free drug programs that you have heard about for those transitional assistance beneficiaries who exceed the $600. I also can report we have already had beneficiaries exceed the $600. So in the first month some of the TA people that we automatically enrolled already have used their $600, and now we are monitoring to see whether the free drug programs through some of the manufacturers are going to kick in. So that was last week's phone calls with Medco was to see how that -- now we have some cases that we can actually track through.

(Slide.)

This is what the card looks like the beneficiary gets in the mail. You will notice that it is dual logoed I think is the term they use. This tells since it has got both PAAD and Medco right there on the card, it tells both the beneficiary and the pharmacy that they have a combined benefit. They didn't lose any benefits. They have a combined benefit in both the PAAD and Medco preferred discount card. We also let them know that over Memorial Day weekend you would be getting a red, white, and blue card, and that was part of the publicity campaign.

(Slide.)

As Susan said, we have had the added benefit for some of our beneficiaries where sometimes they are paying less than $5, and that is because the co-payment under transitional assistance is either five or 10 percent of the cost of the drug. So if you have a prescription of less than $50, many of the generic drugs, the co-payment under transitional assistance can at times actually be less than $5, and we have actually had people call back in say how happy they were that their co-payment is less than $5 and how great things were. We have had presentations. People raise their hand and say, "I only paid $.50. How did that happen?" So some of our beneficiaries are actually receiving a benefit as opposed to just the state of New Jersey realizing these benefits. We have had to explain to people that the transitional assistance does not apply to the co-pay. They still have to pay a $5 co-payment under PAAD.

Another lesson learned was that when we sent the letter out saying "Don't do anything. We are going to take care of everything for you. We are going to automatically enroll you. You don't have to do any paperwork. Let New Jersey do all the work for you," some beneficiaries took that literally and thought that they didn't even need to fill out a PAAD renewal application. So

though there must have been 50 people that reviewed the language on our letters that went out, another lesson learned is never say you don't have to do anything because they won't do anything, and then people would not complete the renewal application.

(Laughter.)

But we have told people that it is probably a good idea to take the new card right away to the pharmacy. We were worried that they would not open the mail, they wouldn't see that there was a new card in there, so even before you go to pick up your refill. I was also anticipating so many of our beneficiaries don't pick up their own medications. Their daughter picks up the medication once a month on their way over to visit mom, and the card would be home in mom's pile of bills waiting for the daughter to come by. So we were trying to get the word out. We did do a press release saying that beneficiaries should be aware the card is in the mail and make sure that the card gets to the pharmacy. I can also say that I think that was one of the press releases that I have never seen hit any newspaper. When you have got a story that is all good news it doesn't seem to hit the newspaper. So that is when we went to the fallback plan where we had our hotline operators manned with all the information necessary in the

event that the daughter does go one month to pick up mom's prescription and she doesn't have this new Medco card. Our hotline operators can walk the pharmacy right through the process.

(Slide.)

So our message to beneficiaries is consistently that "You are not going to see any change in benefits. You have a new ID card, but everything else is the same. You are still only going to pay the $5 co-payment. You are still going to get all the same drugs." And for the population that isn't eligible for transitional assistance, the higher income group, "You still can keep your PAAD benefit. Even though you are not going to be automatically enrolled, you are not losing anything." Again, I would like to stress that we are constantly bombarding our population with information that nothing is going to change, and in 2006 when they get this information from drug cards they are going to be panicking once again because it is going to show deductibles. It is going to show premium costs, and we have been trying to tell them that nothing will change, but then they are going to get written communication from PDPs talking about information that would not apply directly to our population.

(Slide.)

We have been stressing to our beneficiaries that the $90-million permits us to continue to offer these benefits with only a $5 co-payment at most.

(Slide.)

We are looking into what is going to happen, as I said, and worrying about what is going to happen in 2006. We expect that New Jersey would pay premiums, would pay all the deductibles and all the benefits during the doughnut-hole period so that beneficiaries would continue to have the same level of benefits.

(Slide.)

But our concerns are who will determine eligibility for Medicare Part D. We do eligibility. In New Jersey, my staff determines eligibility for SLMB, the specified low income Medicare beneficiary Medicare savings program in my office. So we have seen the difference between a PAAD eligibility determination and a SLMB eligibility determination when you have an asset determination, asset test besides. We have seen how complicated that process is for our beneficiaries, particularly dealing with life insurance, the cash surrender value of life insurance policies that is associated with SLMB eligibility asset tests. It is very complicated for our beneficiaries, very difficult, and would be one area

that I would ask the commission to look closely at.

Since we are determining eligibility already for the population in New Jersey that have income below 150 percent of poverty, we certainly would strongly recommend that SPAPs that have programs like us would be the place that a person would apply for subsidy assistance. They have been working with us for years. Also envision from our standpoint, how complicated it would be for us to get our beneficiaries to go to another agency to apply for the subsidies. They are not going to get anything new or additional as a result of this benefit, but we would have to send them to the Social Security office or Medicaid district office to do an eligibility determination when at least all the income information we have already got already and they are used to applying to us. So I would strongly ask that the commission consider having SPAPs have the ability to be the point of determining eligibility for the subsidies.

As Kim said, we have done some research about how many people would be affected by the asset test. We have 104,000 beneficiaries with income below 150 percent of the poverty level. About 22,000 of them we are projecting would be excluded because of the asset test under Part D. There are also difficulties even making those projections. As Kim said, we are projecting assets based on interest and

dividends. We don't know what the cash surrender value of the life insurance policy of our beneficiaries is, and so those projections are based on taking the beneficiary's interest and dividends and doing a projection about how many assets must they have in order to have interest and dividends of that amount.

Besides the asset test, we are also concerned that for our population having too many different options will mean people just will do nothing. That they will be bombarded with information about formularies and the different benefits available to them under these PDPs, and we will continue to hear what we have heard on the discount card. "Thank you very much. I like my PAAD. I don't need to get involved. I don't want to go there," and that having too much information frequently has people make no decision.

So we are struggling with whether New Jersey would have to mandate enrollment in 2006. We did not mandate enrollment now because of the automatic enrollment process, but that would require a legislation change for both PAAD and Senior Gold statute if the state decided to move into the mandatory enrollment.

(Slide.)

We are also concerned, as everyone has talked about already today, about the coordination of benefits with

several different plans, different pharmacy networks and formularies. Because now just about every pharmacy in the state, 99 percent or more, participate in PAAD, our beneficiaries are spoiled. They are used to having the same, to be able to go to any pharmacy in New Jersey. They are used to having every drug covered. They don't have a formulary. They don't have doughnut holes. They don't have deductibles. They are spoiled, and it would be very difficult to get them to voluntarily go to a Board of Social Services to apply a subsidy under Part D without an automatic enrollment and eligibility being handled through the state.

We are also concerned, as I said before, about file matches. We have already had these little glitches when there is a centralized file match. Can you imagine if each SPAP would have to coordinate file matches with every different PDP in the state and look at not only eligibility but formulary information, and there would be very complicated coordination of benefits and need for information from each of those different PDP plans.

We have also talked about what will New Jersey do. Will we cover a drug that is not in a plan's formulary? It is going to be difficult politically in New Jersey to not do that. Our beneficiaries are used to having

every drug covered, and what will happen in 2006? Would we cover a drug that is not on a PDP's formulary as part of our wraparound? Would we also cover a drug dispensed at a pharmacy that is not in the PDP's network but is in PAAD's pharmacy network? Again, a decision that will have to be made in the state and would have ramifications of how much would be saved by the state, whether we would be paying with state dollars in those situations.

Another issue that gets kind of complicated for us, and I don't think anybody has really talked about yet, is we would envision that we would pay the premiums on behalf of our beneficiaries. Most of our population have income over 150 percent of poverty and would have to pay a monthly premium of about $35 a month. A PAAD beneficiary isn't going to pay $35 a month for a benefit that is no better than or is actually not as good as the benefit they currently have under PAAD. We are envisioning the State of New Jersey would pay the premiums on behalf of our beneficiaries.

We need to set up a system with CMS to do that process, and I know because of doing eligibility for the SLMB Medicare savings plan there is a process to do what is called a buy-in of premiums under Medicaid, and we would like to suggest that that system be revised and expanded to

allow states to use the buy-in process for Medicare part B premiums for Part D premiums for our beneficiaries. Think of how complicated it is going to be especially for that population between 135 percent and 150 percent. They are eligible for a partial subsidy, so every beneficiary in that sliding-scale group will have a different premium amount theoretically, and we will have some people in PAAD with income below 135 percent would not have to pay the premium, that CMS will cover the premium. We will have another bucket of people who are eligible for the sliding-scale premium between 135 and 150 percent, and that amount that would be the state contribution would vary by beneficiary in that bucket. Then for all those 150 percent, which includes our whole Senior Gold population, we would be paying the full premium amount. We need help in setting up a process where that could be done with a file match and an automatic bill-back to the state.

I couldn't imagine having a position where we would have to have our beneficiaries pay the premium up front and be reimbursed. So we would certainly be asking the commission to look into a mechanism to allow us to do a buy-in for our population; particularly keeping in mind the complication of the partial subsidy population where the state would be paying a part of the premium, CMS would be

paying a part of a premium, and all those premiums have to go to each of these PDPs in the state. So that is a complicated process that needs to be worked out, and I would be happy to answer any questions that I can.

Opened for Questions and Answers

MS. HENNEBERRY: We are actually at our time of 12:15, but I do want to make sure that commission members who have burning questions for Kathy get them in, and we will go into our lunch a little bit. So any questions for Kathy? Jim.

MR. CHASE: Jim Chase. Did you consider, and you may have discussed this and I missed it, but having Medco process the entire ---? If I am understanding it, for the pharmacy they process with Medco for the portion of it and anything in balance gets sent to your administrator. Did you consider doing it differently, and if so why didn't you end up there?

MS. MASON: That would have I believe meant giving the whole claims processing system over to -- it was timing mostly that we basically -- I can tell you that from the time we awarded the RFP one week later we were talking to them about sending the enrollment file. The RFP was issued in -- the opt-out deadline was May 10th. We sent the first enrollment file to Medco the following week. So as

far as setting up a whole claims processing system with another entity under the Unisys there wasn't time. Also the claims processing system for those, the majority of our population is not eligible for transitional assistance. Their claims aren't even going to Medco. The majority of our population, they are still just going through the PAAD claims processing system, which happens to be for our pharmacists we use the Medicaid management information system. So the pharmacy community is very used to dealing with processing claims, and we also benefit by having our system coordinated with Medicaid claims processing.

MR. CHASE: Just to follow up to understand, what happens on a claim that falls at what I call the very end of the transitional assistance? I assume it still gets coordinated in the same way if there is still $50 left and the claim is larger. Then on your side, do you only then pay your allowable on --

MS. MASON: No. We agree to allow pharmacies to be paid up to the PAAD reimbursement rate as our way of making sure that the pharmacies would continue to work on that. We were acknowledging the extra work on the part of the pharmacy in having to do the dual billing, so we are taking them up to our reimbursement level, which is higher than most of the discount card. In that period where the

claim would overlap, the pharmacist puts in the TPL field the amount that they received from the discount card and we pay the balance. So again, we wrap around even the last claim under the $600 transitional assistance.

MS. HENNEBERRY: Bob.

MR. POWER: Bob Power. I want to reiterate your statement that there should be multiple ways in which beneficiaries can get into the eligibility determination system and that they are not like dueling banjos and that one decides something on a Monday and somebody else decides something else on a Thursday. Can you explain whether you were thinking that your involvement would be transitional only or a permanent involvement as a gateway?

MS. MASON: Since our population goes over the 150 percent, we would envision that we could handle eligibility for subsidies for everyone in New Jersey since we would like to think that the large majority of the population eligible for Medicare with income over Medicaid limits up to 150 percent of poverty are already in our population. Also since we do eligibility for SLMBs, we have had that experience.

MS. HENNEBERRY: Other questions? Marc.

MR. RYAN: Yes, a quick question. We also have a very different system between Medicaid and our

enrollment in our state-only program. A lot of it is based on self-reporting. I guess one of the questions then, I would like to know if New Jersey has had this experience. Have you had beyond the issues of CMS saying this person is on Medicaid or something of that nature, have you had differences in terms of income eligibility based on what was collected in New Jersey and what may have been reported to the IRS for example that CMS may have asked the IRS for?

MS. MASON: Yes. Thank you, and CMS was very responsive to that issue. We did identify that since they would be matching against IRS records from prior years that we would have situations where a beneficiary on an income tax match is going to show income higher than what was actually their current eligibility, and CMS has given us ability to do an override to accept the state's income determination to override the rejection against IRS records. In New Jersey we do base eligibility on anticipated income, so that made our life a little bit easier since eligibility for transitional assistance is based on current income. In New Jersey we do also base eligibility on current anticipated income with the effort to make sure that a person who is recently widowed can receive benefits in that current year. So many of our population would be just recently retired and have a drastic drop in income. So our

eligibility takes that into consideration and bases eligibility on current anticipated income versus prior actual.

MR. RYAN: Could I just follow up? Is that policy state by state right now with CMS on the discount card, or will that be extended nationally, number one, and do we know yet what the policy will be, you know, going into the '06 range and will be that considered then?

MS. WATCHORN: Again I am looking at Deirdre, but I don't think we have decided that yet.

MS. DUZOR: We definitely have not decided what happens in 2006. However, we plan to work around for the IRS match. We did send out to all the states and ---.

MR. RYAN: Okay. So it has become their policy, and I guess the next issue I guess in a general sense is if state plans are a lot more flexible in determining eligibility on an income and perhaps even an asset basis with regard to disregards and things of that nature, it seems to me that that is another major issue we have to look at. Because if states have to modify their income and asset disregards and how they count certain things, we do not want to -- you know, I think that has to be in place early on so that we are not bucking heads at the end and having people denied access in creating the

confusion that we have heard can even happen with the discount card.

MS. HENNEBERRY: In the early presentation, Linda, you had some questions about outreach and education efforts. Have those been answered?

MS. SCHOFIELD: Yes.

MS. HENNEBERRY: Okay. All right. Any other questions or comments? Go ahead.

MS. SCHOFIELD: I am just having trouble squaring two different facts, and they may be unrelated, but I need to understand them a little better. I think it was the earlier presented had indicated that generally states found that the discounts on the cards weren't worth much other than the $600 subsidy, and so that didn't factor into your choice of plans. But then I just heard you answer Jim's question by saying that you pay the pharmacies at a higher rate under the PAAD program than the discounts do. So how do those two things work together?

MS. MASON: That was one of the issues we looked very closely at during our RFP process. One of the questions on the RFP was "What is the reimbursement rate that you plan to pay for pharmacies?" Because we wanted to be sure that we didn't have problems with pharmacies participating, and actually that was part of the decision of

awarding the contract was even though the discount rate under Medco was lower than ours -- ours is quite generous. It is average wholesale price minus 12.5 percent with a dispensing fee of about $4, which is higher than most plans pay. Even though Medco's network reimbursement was lower than that, they still had at the point of issuing the RFP almost every pharmacy in the state already enrolled in their network. So they were still willing to participate at the lower reimbursement rate. In taking the pharmacy up to the PAAD rate, we just wanted to compensate them for the extra workload of doing the double billing that they have to do.

MS. SCHOFIELD: I understood that, but I guess my point is or my question is then in reality the discount themselves of these cards might have produced some savings for the states if you had opted to use them because they were greater discounts than you --

MS. MASON: If we weren't going to take them up to the PAAD rate. Since we were taking them up to the PAAD rate --.

MS. SCHOFIELD: Thanks.

MR. CHASE: Can I just follow with that? Our assessment would have been that the pharmacies get a higher reimbursement but the discount cards, the cost was a little bit higher because of our rebate situation. So I don't know

if you would be in the same situation that actually it wouldn’t have saved us money to use the cards themselves for the full payment, but indeed the pharmacies probably do a little bit better with our program because of again the differential there being the rebates that we collect directly. But I am curious then in your program what happens with the rebates when -- how are you collecting rebates on drugs that you are paying partial amounts for?

MS. MASON: Julie is smiling because that has probably been one of the biggest issues that we have grappled with on the whole discount card. States are all handling it differently. In New Jersey our legislation that requires rebates actually expired years ago and is only continued through appropriation language that says you will continue to pay rebates, so we didn’t have a strong statute to fall back on as far as the rebate program. In the RFP though we asked the question of these discount cards of "How will you be handling the rebates?" Medco is passing the rebate that they receive to us through on the point-of-sale, and as far as concerns about making sure that we receive savings if I can explain this well, if the -- if Medco passes the rebate through to the beneficiary at the point-of-sale since we are picking up the co-insurance we save because our balance is then reduced by the fact that they

have actually increased the reimbursement to the pharmacy by the amount of the rebate, and actually we have been tracking that and have found that we the group of people that already met the $600 we have cost-avoided over $600 because the rebate was passed through to us at the point-of-sale. Initially we were a little bit alarmed when we saw that we weren't getting cost avoidance over $600, but because $600 was the amount billed to CMS but another $50 was rebates that were passed onto us through the point-of-sale reducing our balance in the co-payment. So that is how we were benefiting from the Medco rebate.

Also we have an agreement with Medco that in any case where they are not receiving a rebate we are going to bill under our regular rebate program. So if it is a non-formulary drug and they have no rebate agreement, Medco doesn't get rebate, we will submit for the rebate. Also after the person reaches the $600, there will a decision of whether they will be eligible for the free drug programs, eligible for the manufacturers. If they get a free drug program we won't bill for the rebate because the free drug program is really a rebate from the manufacturers. But for all other claims over the $600 then PAAD would start paying their -- billing their regular rebate. Now, that varies by state, and I know First Health has had a different

arrangement with New York and Pennsylvania as far as dealing with those rebates.

That was a very complicated issue, and I think that is something that everyone is wondering also how is that going to work in 2006. It was one of those decisions that had to be made very quickly when we decided to pick a vendor, but we did get reassurance in the RFP that rebates from the different discount cards would be passed on at the point-of-sale. Therefore, we would at least -- but it depends on the drug how good that rebate is. It is not standard as it was with the Medicaid-level rebate the state had previously been getting. We are finding some of them are very good rebates, depending on whether it is a formulary or non-formulary drug. Sometimes it is as good as we were getting; sometimes it is not.

MS. HENNEBERRY: Marc and then Donna.

MR. RYAN: That was sort of my question, but I guess to follow up so I understand it. When we did our budgetary look at this we actually discounted. You guys used the $600 times two times the number of people under 135. We sort of discounted the $600 because we felt that the rebate that we were already getting was going far exceed anything that were on the cards. Could you explain in a little better detail why was there -- I would have assumed

in your dollar savings you would have already taken credit for the rebate. I am a little confused about why the -- it is actually over $600.

MS. MASON: Because the cost avoidance that is coming through on the claim includes both the amount that was billed to CMS and since the Medco is passing the rebate through to us. The rebate is actually paid to the pharmacy, so the pharmacy's reimbursement is increased by the amount of rebate. Our balance is then reduced to reflect that the rebate was indeed passed through as an increase in payment to the pharmacy. So they would bill $30 to CMS, retroactively bill $10 to the drug manufacturer, pay the pharmacy $40, and we would pay the balance.

MR. RYAN: But wouldn't that Medco rebate pass through already? Wouldn't that be offset against a lower rebate you would have claimed in your system under the Medicaid program anyway?

MS. MASON: Right. There are times when the rebate we would have gotten under the state plan would have been a higher percentage. I mean, again, we are also paying only 10 percent of the cost of the claim as opposed to paying the full cost of the drug. But as I said, different states are handling that differently. That was a late decision that we had to hurry up and get something

implemented.

MS. HENNEBERRY: We are going to take Donna's question and then we will break for lunch, and if Kathy is still here after lunch and you think of other questions for her while we are breaking then we will proceed.

DR. BOSWELL: Thank you, Joan, and it is really just further clarification on this. So Medco has the ability to tell you which scripts they have collected the rebates on so that you can then scrub them out of your PAAD rebate claims --

MS. MASON: Yes.

DR. BOSWELL: And then --?

MS. MASON: We are going to do that as a match. At the point we go to do our quarterly rebates we will match against a file coming in from Medco saying we have already got rebates for these NDC number. Exclude them from our rebate, and bill the balance.

DR. BOSWELL: Thank you.

MS. HENNEBERRY: Okay. We are going to break for lunch. Lunch is for commission members only and it is on the second floor in the Cabinet Room. For the rest of you we will reconvene in this room at 1:30. Kathy, thank you very much.

(Applause.)

(Whereupon, a luncheon break was taken.)

A F T E R N O O N S E S S I O N

(1:36 p.m.)

MS. HENNEBERRY: Okay. Our first speaker for the afternoon is Dr. Jack Hoadley, Research Professor at the Health Policy Institute here in Washington, DC at Georgetown University. Jack, I think you handed out your remarks ahead of time to us.

DR. HOADLEY: I provided them to the staff. Yes.

MS. HENNEBERRY: Okay. Thank you. Welcome.

Presentation by Jack Hoadley, Ph.D.

DR. HOADLEY: Well, thank you for the

opportunity to appear before the commission. Along with several colleagues, I received a grant from the Robert Wood Johnson Foundation's change in health care financing and organization initiative, or the HCFO initiative, starting this year to conduct a study on the experience of state pharmaceutical assistance programs. Actually when we proposed this project it was before the legislation was passed, and we talked about some things we would like to study in terms of how programs were operating. Now we have tried to modify the project to look at some of the experiences. Basically, we are conducting case studies in 14 states generally looking at states that have had their programs in place for at least two years and have at least 5,000 enrollees in their programs.

As part of the project, we are gathering information on operational concerns such as coordination of benefits, communicating with enrollees, administrating eligibility, cost sharing, et cetera, and approaches to managing drug costs. But as I said, we are also trying to examine how states may be trying to consider modifications to their programs in response to both the Medicare discount card and the Part D drug benefit. In each state we are conducting semi-structured interviews with key state officials, with PBMs, with representatives of pharmacists,

physicians, beneficiaries and so forth. I should also say we are doing some related work for the Medicare payment advisory commission and some of that may be relevant to the work of this group as well.

We are currently in the field doing our case studies and our interviews, and so at this point I can't really report on sort of definitive conclusions about what we are learning. We are still very much in the midst of a data collection phase, but we did think we could share a few initial observations and insights, particularly about the ways that state programs are working with their discount cards. So of these things you have talked about already today, so as you know several states are using auto-enrollment procedures to get cards for enrollees, especially for those enrollees who qualify for the transitional assistance, and there is a variety of ways that they are doing that.

But I think one of the things that I wanted to emphasize is because of the variety of different types of state situations there really is the potential to learn about some of the different types of arrangements and how they interact differently with the new Medicare program. So for example in those states, and you heard about New Jersey's approach that offer extensive benefits that are

pretty much providing the whole benefit package for the people who are qualified, the savings that the discount card allows are mostly savings that accrue to the states that provide the states in turn an opportunity either to reduce state expenditures or to enhance their programs; and the beneficiaries qualifying for transitional assistance in those cases either may be held harmless or in some cases, as again you have heard, may achieve some small savings in the form of reduced cost sharing. But for other state programs, and we haven't heard as much of a discussion of these, some of those are programs that only cover certain classes of drugs, don't cover all the drugs that people may be using. There may be more significant savings available to the beneficiaries who enroll in transitional assistance and even in some cases situations where the discounts available through the discount cards may offer them something they don't get in the state programs. I think it is important to try to make sure we learn from some of those experiences and think about some of the different ways the different kinds of state programs will be affected, both under the discount card and moving forward into Part D.

I think the other thing, and there was a lot of discussion about this this morning, is for any of the state programs that have at least some enrollees who get

discount cards and transitional assistance. There are in some cases new coordination of benefit issues. For example, how to make sure that the transitional assistance value is drawn down before state funds are used; and you heard again New Jersey has a very thorough process, Pennsylvania similarly, and I am sure some of the larger states do. But there are other states that really have not had experience with coordinating benefits because they are not open to people who have any other kinds of benefits for whom the whole business of trying to do coordination of benefits may be a new thing to learn, and again this is an experience that is going repeat itself under Part D. The goal obviously in these situations is to try to make that coordination as seamless as possible to the beneficiary, try to keep most of the burden on the administrative side and possibly on the pharmacy to make sure that they apply the different cards appropriately and try to keep the beneficiary from having to have a new burden in doing this. So I think there is some experience in the state programs.

But I also wanted to try to think forward a little bit to some of the Part D issues, and we have been asking the states that we have talked to so far sort of what their plans are for Part D. As I am sure you are not surprised because many of you are in this situation, the

short answer in most states is it is really too early to start making a lot of plans. In fact, we heard from one state official who said the time between now and 2006 is essentially a millennium in state time and this is just way off the radar screen. Now, that was a statement we heard three months ago, and it is three months later and that millennium is moving forward. So I think, you know, as the clock ticks people are finding themselves in the need to look forward.

But I thought I would draw a few just sort of preliminary observations about lessons from what I have seen so far and just from what I know about the Part D benefit and the state experience, and one I think is that the state programs and CMS are beginning to gain some experience in working together in the discount program and to their mutual benefit. They are learning to work with each other. They have worked out a lot of issues, and I think that is something that can only help moving forward. There is a line of communication that seems to be well established and should help moving forward. But there are other things that are going to potentially make the Part D benefit a significantly greater challenge. For one thing, the Part D benefit is going to affect all state program enrollees, not just the subset of enrollees who may be eligible for

transitional assistance, and it is going to affect all state programs. Whereas the state programs that are operating under Medicaid waivers mostly for the most part could ignore the discount card program.

I think there is also a number of interesting issues and some timing issues in what is going to happen over the next 18 months, and basically that is all we have got now until Part D would be implemented. A lot of the questions like whether auto-enrollment will be appropriate and used for these Part D programs are going to be driven by questions such as what kinds of plans and how many plans participate in Part D, and that is something that we may not know until well into next year, perhaps the second half of next year when plans finally have to -- that want to offer a Part D benefit finally have to make the commitment and start contracting with CMS to do so. We don't even know at this point what the regions are that will be and which plans will be able to offer those benefits, whether they will be small regions the size of a single state or whether they will be much larger regions, maybe only 10 or so across the country. So there are a lot of unknowns and a lot of questions of timing as to when these various bits of information will become available, and then how is it that the states are going to have to make decisions that relate to if it turns

out there are only one or two private drug plans available in your particular state. That is a very different environment, and then if there is the 20 or 30 like we have seen under the drug cards. I think at this point if you ask me to guess on what is the right answer, it depends on which week you ask me whether I say there are going to be a lot of plans or just a couple.

I think that the issue of coordination of benefits again some states, New Jersey and Pennsylvania just to name a couple, have pretty extensive experience, and you have heard a discussion about this morning with how they about coordinating benefits, have already-existing relationships with some of the insurers, some of the revenue departments and so forth to make sure they know how to coordinate things. Other states, this is a very new environment to move into and there is going to be a real steep learning curve, and again I won't repeat some of the issues about the need for data from CMS and so forth to make that coordination work as easily as it can possible do. But I think looking very carefully at the experience under the discount card and what has worked well and what hasn't would be very important here.

From a beneficiary perspective, there are a lot of beneficiaries today as again we heard in the New

Jersey presentation who have very seamless coverage. They have one source of coverage. They really don't want to change that. They are going to be looking at coverage that is going to be coming from two sources under Part D. Now it may be that states like that will be able to work it out in a way that keeps it very seamless in the eyes of the beneficiary, but that is going to be a new challenge. There are other states where the coverage has gaps. As I said before, states where only certain classes of drugs are covered where they may already be operating with a couple of sources of coverage, and in any case the beneficiaries face the ability to fill in the gaps that they have today rather than looking a situation where they can only see their coverage getting more complicated, more difficult. For those beneficiaries they may see improvements while they may also face some complications in terms of coordinating between different programs. So, again, I think it is important to keep in mind the variety of different kinds of state experiences as you go through your deliberations.

Then the basic decision-making process that states will have to face. We heard some this morning from Kim about, you know, state intentions in terms of wrapping around existing benefits trying to make sure that the people who have current benefits have at least as good a package as

what they have today, and maybe some states will choose not to do so. But a number of choices also in terms of whether states want to take the savings that they are going to accrue through the Part D program and in the shorter term through the discount card program to expand their coverage, to add coverage for people in higher income groups, to add some of the classes of drugs they don't currently cover, to add disabled beneficiaries in those states that don't currently cover disabled beneficiaries and so forth. But it is also important to remember that these are decisions that have a lot of complexities behind them. Legislative histories that go back many years in the case of Pennsylvania for example of providing a benefit to seniors, and very much that is part of how that whole benefit has been defined and created back when it was first started. To move that into the disabled population, as desirable as that may be, may face some political obstacles and so forth. Moving to higher income groups may be something that looks very desirable but may run into some political barriers, and I think that is something to think about in terms of what these programs will look like down the road.

Then the last of my observations has to do with the communications challenge, and I think, you know, we have only just begun to try to absorb what the

communications process is going to be like. It was relatively simple I would argue to communicate the changes in the discount card. As complex and as complicated as that was, only a subset of beneficiaries really were affected. You could safely say to many beneficiaries nothing is going to change, and then there were those footnotes like remember to renew your enrollment, but basically the message was nothing is going to change. You don't need the card. You are going to get the same benefit from EPIC or PACE or PAAD that you have been getting before. Under Part D for the most part as it would appear right now, that won't be a message that will possible.

Now, maybe there will be ways to streamline this and create a much more coordinated, seamless program that allows that to be possible, but at least as it would appear today the communication is going to be very different. It is going to include current Medicaid beneficiaries. It is going to include people in the low income bands. It is going to include people in the upper income bands. Communicating with these beneficiaries, as points have already been made, is not an easy process, and also simply the fact that you are having to reverse a message. A message that today you are telling people don't worry, nothing is changing, or very little is changing, or

for those who are getting transitional assistance there is a little bit of a change here, but it is not really going to affect what things look like. Particularly depending on decisions about whether auto-enrollment into a single plan is possible and things like that, the communication message may be much more difficult, and it is going to be something that I know one of the issues for all of you in the states is how do you pay for this kind of effort. You don't necessarily have a budget. Maybe that comes out of some of your savings that you are accruing from the program, but you don't have a budget for communications at the level that this may require.

We did some interviews about sort of what are the current processes that states use to communicate to their enrollees, and in a lot of cases the answer is, well, there isn't a lot of regular communications needed. There is of course every time there is a significant change in some aspect of the program design. A new deductible design, cost sharing, or a change to a preferred drug list or something like that where you have to get out and explain, and the states that have gone through that know that can be a difficult process and it is something where partnerships are going to be important. Partnerships, obviously coordination with CMS, but also partnerships with the SHIP

programs, with AARP and other private-sector organizations who play a lot of the communication and education and outreach roles for these programs. So I think that this is an area that we have found so far is something that is difficult. It is going to be a real challenge to the states.

So that is very quickly my set of sort of initial observations and comments based on what we have done so far, but I want to end by just emphasizing that we are continuing in the field. We have a number of our case studies. Most of our case studies still are either in progress or haven't even started, and we hope we will have an opportunity to come back and share additional findings with you as your deliberations proceed as well as if there are areas of particular interest where our research team can be helpful as we are in the field asking some particularly targeted questions on certain areas. We would be happy to try to incorporate that and to try to provide information that is useful to this group. So, again, thank you for the opportunity to appear, and I would be happy to answer questions.

MS. HENNEBERRY: Great. Thank you, Jack.

(Applause.)

MS. HENNEBERRY: Any questions from

commission members for Dr. Hoadley?

(No response.)

MS. HENNEBERRY: No? Okay. Thank you. Is Tom in the room?

VOICE: No.

MS. HENNEBERRY: No. We will just go with Evelyn. We are switching the agenda a little bit because Mr. Morrison just arrived and I think he is in the hotel, but our next presentation will be from Evelyn Gooden who is the State President of AARP in Illinois. Welcome.

Presentation by Evelyn Gooden

MS. GOODEN: Good afternoon. On behalf of AARP, more than 35-million members, we would like to thank you for the opportunity to address this important commission. Many states have taken the lead in helping people afford prescription drugs through a wide variety of state pharmaceutical assistance programs or SPAPs. AARP has played an active role in promoting many SPAPs. We will continue to work to support and strengthen SPAPs because they help fill the gaps in the new Medicare drug benefit. These gaps in the new Medicare drug benefit make it essential that this commission succeed in its charge to protect the interests of program participants in a manner that is least disruptive to these participants.

The MMA legislation rightly specifies that there must be a single point of contact for enrollment and processing of benefits. We believe that the coordination between SPAPs and Medicare drug plans must be as seamless as possible in every way. To achieve this, there should be clearly-defined responsibilities for how SPAPs and Medicare drug plans coordinate with each other so that there is no disruption to or burden on beneficiaries. Ideally, it would be invisible so individual beneficiaries would not be burdened in any way with the responsibility for tracking which program's rules or payments apply for any given purchase. In addition, coordination should include insuring that SPAP enrollees get the best price available to them, either through the SPAP or the Part D plan. This will help insure maximum savings to both beneficiaries and tax payers.

Several additional factors also need to be addressed. SPAPs generally provide benefits equitably with eligibility based solely on income criteria. The Medicare drug program in its current form subjects enrollees to an asset test that penalizes lower income individuals who have managed to save for retirement but who still need assistance paying for medications. AARP will be working hard to eliminate this asset test. However, until it is repealed there must be smooth mechanisms in place for coordinating

equitably-provided SPAP benefits with the new Medicare coverage and applying the asset test in the least burdensome manner.

The MMA clearly states that SPAP spending may be counted toward the annual out-of-pocket threshold. It does not in any way suggest that this would not apply to waiver-based SPAPs. There should therefore be no distinction between waiver-based and other SPAPs' spending toward individual enrollees' out-of-pocket threshold for the catastrophic coverage cap. Inflicting such a distinction would be unfair, complicated, and burdensome to both states and individual enrollees.

SPAPs vary widely in how they work and who they cover. Requirements for coordination between SPAPs and Medicare drug plans must provide for this variation and not attempt to restrict SPAPs in any way that might create incentives to reduce or eliminate coverage. While many SPAPs were enacted as a bridge to a full Medicare drug benefit, the new Medicare drug benefit itself is only a beginning. More work remains for it to be the comprehensive program that Medicare beneficiaries need and deserve. This commission's work is critical for helping SPAPs to continue serving as bridges until that essential goal is meet.

Now, I will not be able to answer any

questions that you have because it would be of a technical nature, and I am here on behalf of our members to present our position to you. Thank you for this time.

MS. HENNEBERRY: Thank you.

(Applause.)

MS. HENNEBERRY: I think we will go ahead and take our last formal presentation before we take a break. We are now going to hear from Tom Morrison, a pharmacist and Vice President of Pharmacy for CVS Pharmacy from Rhode Island. Welcome.

Presentation by Tom Morrison

MR. MORRISON: Thank you very much. Usually you don't want to speak at lunches or the last speaker before you go on a break, but I will do my best to get through this, although I might have just lost it.

(Adjusting equipment.)

Thank you very much. My name is Tom Morrison, Vice President of Pharmacy Services with CVS. I have been in the pharmacy industry for a little over 35 years. I have been with CVS for just about 30 years, and for the last 15 years I have been lucky enough to be responsible for pharmacy third-party programs at CVS. So I have got a little experience in what has taken place and hopefully will be able to shed some information with you

today. But I am not here just to represent CVS. I am also here to represent NACDS. That is our trade association, National Association of Chain Drug Stores, who represent 217 pharmacy companies throughout the United States who comprise of 32,000 retail pharmacies. Those pharmacies currently fill approximately 70 percent of all the prescriptions that outpatients utilize.

The reason I am here today, however, is that I understand the importance of this commission and the charges that you are having to work through. I would ask that you, as I ask many of my team members at CVS as they start negotiating contracts or putting processes in place, to keep the patient and the pharmacist in the back of your mind. Because as you go through each process if you can create an efficient, understandable, easy process then you will have succeeded in your endeavor. In the few minutes that I will be here with your today I am going to just focus on a couple of issues.

(Slide.)

Two of your charges that you have been provided is to address the unique transition, the unique transition issues, facing the state pharmaceutical assistance programs and program participants as a result of Part D, and secondly to protect the interest of program

participants in a manner that is least disruptive to such participants.

(Slide.)

The chain retail pharmacy industry will be providing the majority of prescription services under Part D and Medicare advantage plans. Community pharmacy becomes the natural primary point of service and primary source of information for SPAP enrollees regarding pharmacy drug benefits. The least disruptive, it will be necessary to provide seamless pharmacy benefit to Medicare beneficiaries, particularly when there are multiple payers. There will also be a need to increase patient care opportunities and reduce administrative burdens of providing of providing pharmacy services.

(Slide.)

Some of the issues, the transition issues, most are self-evident but important to emphasize. I am going to list five key issues here and then go into a little detail on each of them. First and foremost, and I think you have heard it from some of the previous speakers, education for both beneficiaries and pharmacies about the benefit changes; the operation complexities of formularies and pharmacy networks; electric online retail claims processing at the point of service; we are going to spend a little time

on coordination of benefits among payers; and lastly the use of the NCPDP standard benefit card. We all have acronyms. I am not sure if you know NCPDP, but that is the National Council of Prescription Drug Programs.

(Slide.)

The first one is the beneficiary education. Oftentimes most beneficiaries and pharmacists only learn about the pharmacy plan changes when the patient comes into the pharmacy to fill a prescription. Education is critical. I recognize that we are all guilty with not reading our health plan materials when they come to our homes, but getting easily readable information and informative information to both beneficiaries and providers is extremely important. Pharmacies in particular need to be educated about these changes, because oftentimes your beneficiaries utilize the pharmacist to try to get some direction in understanding of many of the changes and oftentimes to give some direction as far which plans seem to be best over others.

One of the key questions that you are going to have to ask yourself a little bit, one of the issues that I will leave you with, is how do pharmacies help beneficiaries navigate through the prior approval or the appeals process. What happens when there are multiple

health plans with each of their own prior approval process? I don't know if there is any opportunity to think outside of the box in this particular case of if there is any opportunity to standardize the prior approval process or the appeals process for this group of individuals throughout the health plans. I don't know if you can find that acceptability, but certainly it would be one to minimize the disruption that the beneficiary might go through.

(Slide.)

Formularies and pharmacies. Some Medicare beneficiaries have been taking certain drugs for many years and may not have their drugs on the formulary or have to pay a higher co-pay. How do you handle that? Formularies have become very sophisticated and complex. It is going to be a challenge to keep it simple and cost effective. Thousands of drug switches may occur because of this program on January 1st, 2006 and years thereafter. One thing I certainly wanted to bring to your attention is that over 60 percent of the private plans that we administer often coincide on that same date. So there is going to be a lot of distractions, not only for your beneficiaries, but also for the pharmacies. I don't know if there is an opportunity to have some of the formulary compliance issues brought in over a period of time rather than all January 1st.

Potential disruption in the continuity of care if a patient's pharmacy in a network or has to pay out-of-network rates. Certainly your statute gives you that opportunity to have restricted networks, and I recognize the advantage of gaining market share when I am negotiating contracts. While I am generally a proponent of restricted networks, this membership is transportation-dependent as you recognize, and limiting pharmacy participation will be very disruptive both in relationship and confidence that they have in their pharmacist and pharmacies that have been built up over years of shopping at those particular stores and obviously impact access.

(Slide.)

Real-time pharmacy processing. You may be aware that the pharmacy industry has pioneered the electronic claims process to create efficiencies in our business. I would ask that you thoroughly rethink any process that may fall back to a manual operation. I have identified some of the key issues that need to be taken care of electronically. Dual coverage, where we need to have access to eligibility issues about the patient, the drug, the physician, co-pays, resolution of rejections fairly quickly, if not online then through a call center that is very responsive and receptive. Overwhelmingly the majority

of the prescriptions are processed online, real time using the NCPDP 5.1 format for drugs and supplies. Where we run into disconnects oftentimes has to do with DME supplies and whatnot. Oftentimes the majority of the prescriptions are online, but then we run into hiccups in other areas. Patient care requires DUR in real time to detect drug interactions and costly duplicate therapy.

(Slide.)

Coordination of benefits. This is a tricky presentation. I haven't seen this presentation before now, but they are bringing it out one bullet at a time. Historically -- and you may know this -- historically the insurance industry has managed COB. There have been multiple insurers involved, subrogation. They have got a process and a mechanism to be able to handle that. As time has gone on, oftentimes many of the government programs, the state programs, have requested their providers, including pharmacies, to pick up this activity. But providers have difficulties in managing this function for a number of reasons. First of all, not all pharmacies participate in all plans, and so when you start doing a coordination of benefit all of a sudden you get rejections or you have to start coordinated activities between the plans that don't participate. Or the worst-case scenario is that you have

got to tell the patient after they have called in for their medication a day ahead of time, they have waited in line maybe upwards of a half-hour to get their medication, that the pharmacy is not able to fill the prescription and they are going to have to take it to an alternative location, and perhaps they don't have the transportation to get there that day. So envision many issues that need to be addressed.

Billing sequence, well there are a number of those issues. Who is going to be the primary and who is going to be the secondary payer? Medicare, how do we know? How do we know when they play the role in this process? Information, there are two alternatives that I will sort of raise to you today. One is could the information be put on the card regarding multiple payers? Would that facilitate the activity taking place in the pharmacy setting? Whose benefit must we follow? Unless you have actually worked in a pharmacy setting or in some other setting where you have got to coordinate benefits -- you can understand the difficulty and the complexity when you are talking between two different plans that two have two different benefit designs, two sets of formularies, two sets of co-pay structures. Sometimes the physician is covered; sometimes the physician is not covered. The complexities are just overwhelming, and trying to resolve that is extremely

difficult. But there are a number of things: Are the drugs not covered, plan limits exceeded, consistent prior approval processes as I have indicated earlier, and knowledge of formulary exceptions.

(Slide.)

Facilitating the COB process. A database of insurance information on beneficiaries or other coverage should be potentially the processor's responsibility. Provide information in a real-time manner through an electronic system, and then tell us who is the primary and secondary through this electronic communication vehicle. We need to set up a process that really must avoid recoupment activities. Generally that occurs when we are not provided the information up front, so we are not able to manage that portion of the COB process. Then lastly to provide information regarding insurance coverage for prescriptions only.

Before I get into paying for the COB information, the other alternative that certainly I was thinking about earlier was can there be an umbrella organization, an entity that could actually capture the information during enrollment time, keep the information in a database, have a process to manage the changes, fall back to a system that has already been proven and works well in

the insurance industry. Which is you accept the payment from the pharmacy regardless of the pharmacy. You know the limitations because of the various channels that are out there, the other insurance agencies and whatnot, and have this entity coordinate this activity behind the scenes. That would, number one, reduce the disruption to your beneficiaries, minimize the confusion that may occur at the pharmacy, and ultimately insure that you are getting the payment distributed in the proper channels. Both hybrids work. I think we have tried to migrate to get the providers to handle this process without allowing the providers to have a mechanism in place to handle it extremely well.

(Slide.)

Paying for COB information. Well, who should not be responsible? I can probably identify a few there. The patient obviously, number one, and I have got concerns very much with the pharmacy providers, because in the system today what it does is adds increased work. You have got to bill now, bill it again. You have got to handle rejects, you have got to handle again. Everything is duplicated. Prior authorizations, you have got to call each organization and deal with them separately. Increased training costs obviously. Increased system costs, because now our computer systems need to be adapted to handle additional information

that they didn't have to in the past. Increased processing costs, and finally increased payment issues. COB is a very difficult process for a provider to handle, and I would challenge you to think if possible are there other alternatives that we might be able to think about at this point in time.

(Slide.)

Lastly, the standard benefit card. The use of the NCPDP standard benefit card is important to facilitate claims processing. It insures that all the necessary information is on the card and it promotes easier recognition on the part of the pharmacist. It should indicate on the card that the person has other coverage if you go down that hybrid or that alternative way, and it should be in use when the benefit starts in 2006. One of the most difficult processes for both patients and pharmacies is eligibility and understanding what their coverage may or may not be, and so the card is instrumental in the pharmacies to be able to facilitate communication with other entities to understand what should be covered and what shouldn't be covered. Lastly, if the pharmacy does play a role in COB, the card should allow the pharmacist the ability to electronically access all information needed to bill multiple payers.

(Slide.)

Lastly I would like to leave you with just three or four key points. One is that obviously retail pharmacies is where the rubber meets the road in providing drug benefits. The ease or difficulty of your benefit design, the result of your educational effort, will be demonstrated in our pharmacies. Most pharmacy claims are successfully processed in real time in just seconds. We don't want lots of frustrated customers, neither do you. It is important to adjudicate all the activity in an online fashion. Information in a real-time manner is key to driving this system forward, maximizing efficiencies and creating satisfaction for both your member and my pharmacists. I would be remiss if I didn't also suggest an efficient COB process where the entity responsible could supply the necessary data to the alternative payers and collect the accurate monies from the alternative carriers. With that, I will handle any questions or comments that you may have of me.

Opened for Questions and Answers

MS. HENNEBERRY: Questions for Tom from commission members? You are awfully quiet after lunch here. James and then I think Marc.

MR. CHASE: You mentioned for COB I think it

sounded to me like a system behind the scenes so it isn't just on the pharmacy to do the coordination. Could you talk a little bit more about how you would see that as working? I am a little daunted by that. If there were, if I am understanding it, five carriers in a region I could see trying to work together to set that up, but if there is an unknown number it would be much more difficult.

MR. MORRISON: The key thing is that we are not reinventing the wheel, and you may want to talk to organizations like Aetna or Cigna or other insurance carriers. They have had systems in place for years to manage COB activities and subrogation as they go through their issues, whether it be car insurance or any other issues, health care or health insurance. In their settings they would have agreements or arrangements between the various carriers so that they could exchange information between those carriers and be able to manage the coordination of benefit process. They all have a part in this process, and they all want to be able to make that process work efficiently and smoothly. So they have the incentives to try to create process that works extremely well. State programs I think also tried to do it themselves and didn't do it well, and I think that is where they were looking to maybe do some cost avoidance processes while

trying to put on the providers' hands the COB process because they couldn't manage it well themselves. Because you have got to be able to capture that information during enrollment time to understand the multiple alternative coverage that a patient may have, and then you have got to be able to tie into that patient routinely in order to catch changes that occur. So it is a process that is probably handled -- I would assume, handled well retrospectively without disrupting occurrences that are taking place at the point of care, which affects your member and affects the pharmacy at that point in time. We have had to handle it, but it is cumbersome at best.

MR. CHASE: Right. I think that is going to be the challenge for us here is in your two issues that you find to be very important. One is that online processing, is in my experience is what other sort of COB folks don't have to do. In car insurance you wait and pay later. You settle up later. It isn't necessarily online, and true often with a lot of the medical stuff. So I think the real challenge to us how do we get there but, as you say, also make sure that the payment is right there when the patient is standing there so everyone knows what has been done.

MR. MORRISON: Right, and the key thing, too, to remember is that all pharmacies don't participate in all

plans. So we have found ourselves in the predicament of trying to address those problems, both online when the patient is in our store as well as retrospectively when we find out that there was some coordination of benefit activity that was requested.

MS. HENNEBERRY: Marc, did you have your hand up earlier? Okay. And then Sybil and then Bob.

MR. RYAN: Just a quick question. The whole issue about pharmacies and the administrative burden of participating in multiple plans, multiple cards for example in this case. Are the decisions that you guys are making at a corporate level or at region level, is it more associated -- is it as much about the way that card may operate or not operate versus the actual financial incentives? I mean, are those issues?

MR. MORRISON: Absolutely. I have two things that I train all my folks to learn, and that is when you are putting together a contract you have got to address not only the financial issues, but also the administrative issues. I have turned down programs that are administratively difficult to handle. If I find a card is going to require additional hurdles for my pharmacist to jump through, that is going to cause negative customer service activities at our stores, I would elect not to participate.

MR. RYAN: And so if a state like Connecticut for example, which mandates to be a CONPACE provider, has to enroll in all discount cards, we are putting a significant burden on --

MR. MORRISON: Absolutely.

MR. RYAN: Especially an independent pharmacy.

MR. MORRISON: Absolutely. Because then we are not able to make a prudent decision predicated on either the financial or the administrative issues. We are being forced to participate for the sake of our customers, and that is extremely difficult.

MS. HENNEBERRY: Sybil.

MS. RICHARD: Thank you, Tom. I think just to follow up with what you said, we are already halfway there with the coordination of benefits. I think, you know, you mentioned who NCPDP was, but what you didn't mention was that NCPDP provides a conduit for coordination of benefits, and in fact most of the private plans are already using NCPDP to coordinate those benefits.

MR. MORRISON: Sybil, as you know, with NCPDP it is a standardized -- it is an organization that develops electronic standards for our industry, so we were successful in introducing an electronic claims submission back in 1990.

Probably one of the earlier groups within the health care industry to do so. We have created in the new standard a portion that does address COB, but it still doesn't address a lot of the other issues that I was trying to highlight. But to your point, Sybil, we do have an electronic standard that provides certain fields to be populated when you are going through this COB process, but it doesn't eliminate all the hurdles that I was trying to bring to your attention earlier. Okay.

MS. HENNEBERRY: Bob.

MR. POWER: Bob Power. Why are you not putting CMS forward as the candidate for that entity?

MR. MORRISON: The entity could be anyone. It could be your PBMs. It could be CMS. It could be anyone. The entity is not restricted to any organization or any group.

MR. POWER: And as I have been thinking about what populations are going to have COB involved, and it strikes me that this is the primary one that will create COB problems. Do you agree, or do others know of other large subpopulations that will have COB activity?

MR. MORRISON: I would agree. I think the issues that we deal with most in our environment is the Medicaid and Medicare recipients. So I think CMS certainly

is able or has the ability to address both.

MS. HENNEBERRY: Dewey, did you have your hand up earlier?

MR. GARNER: Yes. Dewey Garner. Tom, I guess the question that I would ask simply is, you know, to keep it online and move it smoothly it seems like everything needs to be on the card. Which seems a given, but that is not necessarily true. I guess maybe addressing specifically what should be on the card, particularly where there are multiple cards.

MR. MORRISON: One of the things that our industry tried to deal with, oh, five or so years ago as Sybil sort of mentioned. Recently we came up with a standardization of what the health care card should look like, and the reason being is that we were encountering a number of health care companies and PBMs and whatnot that would just put the information that they felt was important, but it didn't suffice. It didn't provide the necessary information in order to provide pharmacy services to that customer who came in or to address their problems when we encountered rejects through an online system. So that standard I would suggest to you might be a starting point and provides the necessary information that is needed in the pharmacy industry anyway to process the claim as efficiently

as possible. The difficulty, I will make you aware of the difficulty, is that dependent upon the type of card you choose every time things change then the card needs to be reissued. That can be a costly process. So you want to think through the process of how can you maximize the utilization of the card and still minimize having to reissue cards unnecessarily.

MR. RYAN: Can I follow up on that real quick?

MS. HENNEBERRY: Sure. Go ahead, Marc, and then Jay.

MR. RYAN: Real quick. You said "we". Are you talking about the association of chain drug stores or NCPDP?

MR. MORRISON: Well, I have a tendency to use "we" all the time. I am sorry, but I am really speaking from my own experience. But certainly I think my experience shouldn't be that different than the rest of the pharmacy issue, and I have been active in NCPDP for umpteen years. I think they want me to retire.

MR. RYAN: So it is really that group that created those standards.

MR. MORRISON: Yes. NCPDP, we use that as the organization that creates standards within our industry

to get consensus before implementing something that can be utilized.

MR. RYAN: Thank you.

MS. HENNEBERRY: Okay. Jay, did you have your hand up?

DR. CURRIE: Jay Currie. I agree with you, this reissuing of cards and is what is on the card what is actually in place right at this point. I don't know, so I am asking a question about is NCPDP looking at a standard? If we have the central repository of data of here is Ms. Jones and she has this coverage, is there a standard being looked at now just to get that stuff real time back to the pharmacy computers rather than having to deal with manual entry of that information off a card? I mean, at some point in the future we don't need the card. We should be able to just get that stuff real time, either I would hope before you submit the claim.

MR. MORRISON: Correct.

DR. CURRIE: I mean, you connect on. You would say I want to fill a prescription for Ms. Jones. It would go out there, grab her information, and then you could go about filing your prescription and know what you were dealing with up front. Is there any move toward that direction?

MR. MORRISON: I can't answer for NCPDP or what they may have on their docket as far as whether or where they may be going. But I would agree with you that at some point with the way the technology is going we certainly have a capability to be able to access it at some point, given all the security and confidentiality information that we have to, you know, build in there.

DR. CURRIE: Because I think that some of the problems that we have in pharmacy have to do with I am trying to fill a prescription given the information I have about coverage, and that causes rejects because we have got -- there are just errors in that data, and I think that is from a coordination and how to make this thing seamless if you start out with having a lot of better data up front then start with some data that some percentage of it is always going to be wrong.

MR. MORRISON: Absolutely correct. I agree with you.

MS. HENNEBERRY: Other questions from commission members? Martin.

MR. SCHUH: Would you do me a favor and walk me through what you would consider a good, clean claim at the pharmacy and then a bad claim if it involves coordination of benefits at the SPAP level? And what would

you envision as a great transaction?

MR. MORRISON: Okay. A clean claim is generally where the pharmacy is able to extract all the information necessary to process the claim once. Now there may be DUR issues that need to be addressed and that kind of thing, but that is not -- I don't consider that a bad claim. So you are getting the correct medication, the patient information, the physician information, and you are able to pass that information to the payer. They are able to respond in a timely fashion. We have issues of PBMs not being available. They have been down, and so being able to get that information passed quickly and thoroughly. That would be a clean claim, and then getting paid.

Interruptions from that, whether there is a number of reject information suggesting that the particular product is not covered, the pharmacy is not covered, the physician is not covered, the patient is ineligible or the patient is not on file, and then you have got to go through the process of trying to identify what component needs to be fixed. Oftentimes we get rejects for date of birth. We have got the correct date of birth from the patient, but the database has the wrong information in there, and so we spend an inordinate amount of time trying to correct that information between the systems. So anything that creates a

hiccup on the part of the claim from being processed smoothly I have a tendency to be concerned about. Now COB just adds to the complexity and adds more issues that have to be addressed.

MR. SCHUH: Well, I guess my question was is that if there is a co-pay involved, both from the PDP in this instance and the state pharmacy assistance program, how would you run that through? Would your methodology be you would hit the PDP first, or you hit the SPAP first, or how would you do that I guess in a perfect world? How would that go smoothest is my question.

MR. MORRISON: Generally the co-pay information is passed back to us by the intermediary or the payer, and it is identified to the pharmacy what that co-pay is. They can change, so we can't rely upon past history being the same information on a go-forward basis. But keep in mind the complexity of -- you know, I refer to the complexity and sophistication of formularies. Obviously what has transpired is there are multiple tiers for co-pays. There is the first, the second, the third, the fourth, the whatever, and I will tell you I have faced patients who are extremely confused, not understanding why one is $10, one is $20, one is $35. They don't understand their benefit design. They can't understand why the $35 can't be $20, and

so that falls back to the educational component. Trying to keep a process or a program simple is going to be a challenge for you, and trying to be able to create some consistency between the various plans out there, particularly when you entertain the COB process. That just adds to the complexity.

MS. HENNEBERRY: Barbara, did you have something you wanted to add?

MS. EDWARDS: If I could. I think it is just more on this point. Again for the carriers who today in your opinion do a good job of coordination of benefits in a way that is friendly for the pharmacist and the consumer, does that mean that at point of sale the pharmacist can figure out from your computer screen who the right carrier is to bill for that drug for that consumer at that time? Or is it that the plans have a way that they have worked out that regardless of who you bill they sort it out later?

MR. MORRISON: I will answer it in two ways, like you asked it in two ways. Recognize that my customer comes to our store in a couple of different ways. They may walk in, and we can ask them information or they can supply an ID card, and we can send a claim off to an agency and we will receive information relative to their coordination of benefits and the patient is there. But over 50 percent of

my maintenance medications for my customers at CVS anyway is filled through an alternative means. Generally they might use phones. They will use an IVR system to request the prescription to be ordered, or some will use -- we have a web alternative. They can use websites to request refills. So in those situations we really rely upon the agency to tell us is there any alternative coverage for this particular patient. We may not be aware of it. The patient, even when we ask the patients oftentimes "Do you have any other coverage?" oftentimes they say, "I don't think so." So it is complex from the standpoint of being able to assimilate all the information necessary.

So from the perspective of how we are dealing with that particular customer, that in itself creates a few burdens. So we truly rely upon the intermediary of the payer, the PBM that is sending us information back. There is a field that they need to identify to us where this alternative coverage is so that we can deal with it. The simplified versions is when there is only one other alternative, and they might send back that, you know, there is Medicare coverage or a state Medicaid plan. That there is Medicare coverage and we can submit to Medicare and come back, and that is simpler.

MS. HENNEBERRY: Linda, did you have your

hand up?

MS. SCHOFIELD: I have heard from pharmacists in the past that one of the difficulties in commercial insurance as well as Medicaid is when an individual comes with a prescription and the claim is rejected. The information isn't always 100 percent clear about the basis for rejection. Is it because the person has come back for a refill too soon or because they don't have prior authorization, or there is a medical contraindication, and there is, you know, a different action that ought to happen in response to those? My concern in a coordination of benefit kind of way is here we have states who are saying, "Well, we will wrap around. If something isn't paid for by the primary payer, we will just go ahead and pay for it." So if it isn't 100 percent clear to the pharmacist that what is required is to go through prior authorization or to tell the patient to wait three days until the end of the month and come back and then their primary payer will pay, that it makes easy for the pharmacist to simply say, "Oh, the heck with all that. I will just bill it to the secondary payer." Which is the state, which is going to increase their budget costs, or which may in fact even be dangerous to a patient if the reason that you are getting the rejection is because the patient has a duplicate medication or a

contraindication. Can you just comment a little bit about the information flow and what you see as issues there and if you have any recommendations?

MR. MORRISON: Sure. I alluded earlier that there are two issues that we focus on when we are managing contracts, and that is the financial issues and administrative issues. We have taken it upon ourselves and I think the industry has attempted, but CVS has, and that is meeting with a number of the various PBMs and large payers to get reject information in English. Years ago they would just send you information that was very cryptic and you couldn't figure out exactly what it was. To your point, it was very unclear. So we have been fortunate to be able to get them to start refining the reject message information. Things like, I mean, we used to just get rejections for, you know, the product is not a formulary product. But they would never tell us, well, what is the formulary product, and so we would do -- there would be these enormous numbers of phone calls being made back and forth to try to figure out what is really covered, and then we have to call the physician to get them in the loop in order to get a change in the medication. The date of birth issue that I raised earlier, we have gotten some PBMs now to tell us the wrong date of birth, but here is what we have on our system. So

we do it electronically rather than having to do phone calls simply because oftentimes it is an input error on their part or our part, and so we are trying to correct that information. So we have taken steps to do that.

As far as trying to address the latter part of your question, which is, you know, what is the shortcoming to not having clarity or understanding anything, what is the impact to the states', you know, budget themselves if pharmacies just redirect all the claims to the Medicaid. I can't speak to that. I am not familiar with that. I do get some. We are dealing with various states who want to recoup, what I call recoup monies due to COB issues, but more times than not I can demonstrate to them that they didn't provide us the information up front. That is usually my challenge, but they are fiscally strapped and looking for any way to save some money.

MS. SCHOFIELD: I think it may be something that we as a group want to take a look at, is what standards do we want to make sure apply to the PDPs to assure that they give the pharmacies adequate information to bill the primary payer, and then what due diligence do the pharmacies have to go through to pursue the primary payer before crossing over the claim to the secondary payer. Otherwise it becomes too easy to just bill the SPAP for everything.

MS. HENNEBERRY: Other questions? Dennis.

MR. O'DELL: Dennis O'Dell. I just wanted to add and, Marty, get back to your question of, you know, sort of what would be the ideal situation for community pharmacies. Certainly, you know, just processing the claim one time and let the multiple payers sort it out after the fact would be ideal for pharmacies and I think for patients, and that may not be something that would be achievable, certainly in the short term. So second to that, there certainly are some alternatives that at least having real-time, clear communication, you know, back to the pharmacies that would make sure that the disappointments and disconnects that we all are charged with avoiding here of having to, you know, get into an inquiry in the pharmacy with the patient or the patient's representatives that are oftentimes the least likely to know the answer to some of the questions that they would potentially get asked at the pharmacies.

I think that one of the goals that we should set for ourselves is, you know, maybe be can't solve all of this in the short time period that we have, but to get back to Linda's point at least if we can, you know, put some standards out there and some expectations, you know, both for the plan sponsors themselves and for something that is

realistic for pharmacies that we should try to make that happen. Because I think that as someone said earlier in a presentation that, you know, it seems as though sometimes pharmacies are not very cooperative on some of the administrative issues. I don't think it is anything that the pharmacies desire to be uncooperative. The pharmacies just would say, you know, "Give us the information so that we can make, you know, good real-time decisions to take care of patients," so that we don't disappoint them at the time that all they are saying or their representative is saying is, you know, "I have got a prescription. I have got a need." You know, "Give me the medicine."

You know, just like the comment that was also, you know, said earlier that if the administrative hassles are so burdensome for some of the state plans, some may decide not to play in the game. I think one of our goals is to make sure that we don't let that become an excuse for any of the participants to opt out of playing in the game. I think we owe it to the beneficiaries to try to do everything that we can to streamline the administrative process, and certainly this area in the pharmacies if we just throw that ball over the fence and say, "Pharmacies, you know, you take care of it," and then know that there is going to be disappointment on someone's part then we

probably haven't done all that we could do to try to avoid that.

MS. HENNEBERRY: Sure. Martin and then did I see a hand over here? No? Then Barbara then. Okay.

MR. SCHUH: I agree with you 100 percent, Dennis. I think a lot of Tom's probably comments are addressed or could be addressed to PDPs or MAPDs, depending on who actually the card belongs to, and I guess given our charter what can we do to influence that positively for the pharmacist. That, I am trying to sort that all out as, you know, what can this commission do. You know, either by regulation or otherwise to make that kind of happen on the PDP side.

MR. O'DELL: And I think that is an excellent question, and I think that that is something that certainly from pharmacy that is represented, you know, both on the commission and others that are interested in pharmacy, that one of the things that we could do is to come back to the commission with some suggestions that would answer your question.

MS. HENNEBERRY: Barbara.

MR. MORRISON: I guess that is the benefit of having both Dennis and I here.

MS. EDWARDS: Barb Edwards. Yes, and I don't

want to belabor it, but I think Linda made a point and others are sort of echoing it. Our experience has been, and I think someone said this earlier this morning, that in fact the actual experience particularly if the state program is a secondary payer is that there isn't a lot of incentive for the private plan to cooperate in sharing the information. We shouldn't start with an assumption that in fact all parties are equally interested in sharing that information, because that certainly hasn't been our experience to date with Medicaid and I think with some of the other pharmacy plans. There is actually an incentive not to provide as much information about other coverage because there is the hope that the state plan will cover it. So I think it is going to be very important that those expectations be spelled out, and then if there are things states also need to do to make it work better that is also important to know. But I think we should be careful not to assume that all parties come with an equal incentive to share the information.

MS. HENNEBERRY: Any other questions for Tom? Bob.

MR. POWER: Bob Power. Tom, can you expand on your description of the available COB systems in NCPDP 5.1 now? Are they lots of empty buckets waiting to be

filled? Are the well defined, or have you just waded into those waters?

MR. MORRISON: We are just, you know, getting into that. It has been released in the not-to-distant past, and so as a company we are just beginning to utilize that in certain situations. So I couldn't speak to it and do it justice.

MR. POWER: So as a follow-up, you could not for example distinguish between health plan A's formulary versus health plan B's formulary?

MR. MORRISON: I am not sure that we can.

MR. POWER: For COB purposes?

MR. MORRISON: I am not sure that we can, but we could get that information for you. We can get NCPDP to be able to provide that information if you would like it.

MS. HENNEBERRY: Okay. One more, one last question. David.

MR. CLARK: Yes. My understanding on the NCPDP 5.1 is you can put multiple carriers on one prescription. It doesn't mean necessarily that the claims processor can deal with the multiple carriers yet anyway. So it is more futuristic and is a preliminary step, but we are kind of a long ways from that. So there is still a challenge, and I just wanted to reiterate something Linda

mentioned earlier. It is critical that if one doesn't cover something for a reason that it doesn't just get passed on to be paid by another if there is a clinical reason it is not covered. One of the challenges we face currently is even with the old 4.2, but even with 5.1 in NCPDP there is a lot of room for messaging. Not all pharmacies when that messaging comes back do anything with that messaging. Some of their systems actually don't even show it on the screen because there is limited space. So we have to be careful not to have too high of expectations unless something is specifically mandated.

MS. HENNEBERRY: Okay. One last question, Marc?

MR. RYAN: While this was sort of the goal of HIPAA, could you just comment quickly if from your work you have seen any HIPAA sort of barriers or things that you have got to overcome with the concept of coordination of benefits and integration like a unicard or anything like. Have you identified any of those issues?

MR. MORRISON: No. Actually I haven't gone down that path, but just, you know, off the top of head obviously we are going to have to be able to protect the information and only be able to capture that information that is absolutely necessary to fill the prescription. I am

not sure if there is going to have been any hurdles relative to the consumer giving permission to access that information, but that may have to be. That may play a role, and then there is going to be other issues as well relative to the sharing of that information with other parties. But for payment purposes, that is one of the exceptions to allow that to occur.

MS. HENNEBERRY: Well, thank you, Tom, very much.

MR. MORRISON: Okay. Thank you.

(Applause.)

MS. HENNEBERRY: Before we take a break, two things. I am going to give the commission members one more opportunity. I think all of our speakers are still here, but I see their suitcases close by. So before they leave and since they won't be here tomorrow with us, any final thoughts or questions for any of the speakers that we have had today from commission members? If you thought of anything over lunch or --?

(No response.)

MS. HENNEBERRY: No? Everybody okay? And then the last thing before we take a quick break, after we -- when we come back from the break this will be the opportunity for those of you who have been listening all day

and sitting back there and took the time away to join us to ask questions. You would be welcome to ask questions of commission members or any of the speakers who are still here as well. So if I could just see a show of hands of who would like to make a comment or ask a question, and I will know a little bit better how to allocate the time for you.

(Show of hands.)

MS. HENNEBERRY: One, two, I see three hands? Okay. So we will take a 15-minute break, come back at -- I haven't changed my watch. What time is it? Quarter to 3:00? Okay. We will come back and reconvene right about 3:00, and for those of you who want to make statements we will give you each about five minutes.

(Whereupon, a break was taken.)

Open Session for Public Comments

MS. HENNEBERRY: Three people raised their hand before the break, and anybody who didn't raise their hand and changed their mind? Okay. I will ask that you just take turns going to the microphone. Please tell us who you are and if you are representing any particular organization or association or state, and we will give you, each person, five minutes to make your statement and then another five minutes for any questions or clarifications from commission members. Just volunteer, anyone. Would you

like to go first?

Comments by Linda Flowers

MS. FLOWERS: Hi. I am Linda Flowers and I am in the Public Policy Institute at AARP; and I didn't hear a lot of discussion today about point-of-service denials, and I would like to ask that the commission seriously entertain thinking through some policies that they might put forth to recommend how we might deal with this issue. I see it coming up in two ways. One is the inability to pay the co-payment at the point of service, which raises issues whether or not the SPAPS will be coordinated in the system so that won't be an issue, or if not, if it is a, you know, two-step process, the person will then be caught in the middle with not getting the drugs that they need, et cetera, while you are sorting that out with the secondary payer. So I would urge you to think through various permutations of that and how you might develop some policies, and on the side the problems that were alluded to earlier on the coordination of benefits, vis-à-vis the claim system. The only thing I would ask you to think through about that issue is if there is a problem and the date of birth happens to be wrong or whatever, are we looking at temporary dispensing? Are we looking at, you know, some sort of process that will protect the consumer? Thank you very much.

MS. HENNEBERRY: Thank you, Linda. Any questions from commission members or comments for Linda? Yes, microphone please. Sorry.

MS. SCHOFIELD: You might want to just describe what you mean by temporary dispensing in case everyone doesn't understand. You are probably alluding to the Medicaid type rules?

MS. FLOWERS: ---. (Away from mic.)

MS. HENNEBERRY: Do you want to go back to the mic, Linda, and just give us a one sentence of what you are --? Otherwise it won't get in the transcript.

MS. FLOWERS: I think the other Linda said that very well. Basically Medicaid has a lot of rules and I hope that is some work we will be able to look at in the future, is what kinds of legal protections have people lost by moving into this benefit from Medicaid. That is a whole other discussion, but Medicaid-like rules which provide that you can't do a point-of-service denial, you can't deny dispensation because of inability to make the co-payment. There are a whole host of rules in Medicaid that protect the consumer from not getting medications they need at the times that they need them, and to the extent that you can maybe adapt some of those rules to this new program. Especially for SPAP individuals who are at or below 135 percent of

poverty. I think that would be very useful. I mean, there is a point at which you kind of go, okay, you can't pay the co-pay and you are at 200 percent of poverty, but for people at a very low income it could be a real issue, particularly if they are on multiple drugs. So I would urge to think through the various permutations on that. Thank you very much.

MS. HENNEBERRY: Thank you, Linda. Okay. We had somebody else? Go ahead.

Comments by Christin Englehardt

MS. ENGLEHARDT: I just have a quick comment. I am Christin Englehardt.

MS. HENNEBERRY: Okay. I am sorry. Go ahead.

MS. ENGLEHARDT: Is this working? I am Christin Englehardt with Health Assistance Partnership, and we work very closely with the 54 SHIPs in every state, the District of Columbia and the three territories; and I was very pleased to hear the references to the SHIPs today and also very pleased to hear the commission's concern for educating the beneficiaries about Part D, and I just wanted to reiterate the importance of the commission's considering thoroughly the role SHIPs can play. They play an important role with the Medicare-approved drug discount cards, and

they can continue to play an important role in educating Medicare beneficiaries about Part D as 2006 approaches. States should really take advantage of the efficient infrastructure and the use of volunteers that SHIPs have already in place to reach the beneficiaries and their caregivers, especially as SHIPs are very familiar with the SPAPS already. I think states would do well to expand the reach of the SHIPs by providing grants to the SHIPs, and this would be a wise investment of the grants mentioned earlier by the Secretary.

MS. HENNEBERRY: Could you take 30 seconds and just explain what that acronym means and who you are and --

MS. ENGLEHARDT: Oh, I am sorry. When I heard the SHIPs mentioned --

MS. HENNEBERRY: Well, some of us know, but I am not going to assume everybody does, so --.

MS. ENGLEHARDT: They stand for State Health Insurance Assistant Program, or SHIPs is the acronym. They have been in place for more than 10 years now working on educating Medicare beneficiaries and their caregivers about all aspects of insurance. You know, Medigap insurance and dual eligibles, what is the best thing for a Medicare beneficiary, and SPAPs play an important role in helping

Medicare beneficiaries get coverage. So the SHIPs are very familiar with the SPAPs, and they will be trained thoroughly on Part D. They have already done a lot with Medicare-approved drug discount cards, so it makes sense for the SHIPs to actually play a larger role in educating Medicare beneficiaries as you all have been talking about.

MS. HENNEBERRY: And how are SHIPs typically funded?

MS. ENGLEHARDT: They are funded through the federal government, but some states also give supplemental funding to the states. So it is definitely possible for the states to provide the funding for it, and actually at this point they have gotten some more federal funding, but they actually have to write the grants for it. We have worked a lot with the SHIPs on actually expanding their capacity through technology, the improved use of volunteers, and also with our outreach. We have done a lot of working with them with flyers. They will make presentations at senior centers, at religious institutions, anywhere that there are Medicare beneficiaries and their caregivers to explain about the Medicare-approved drug discount card, which card is best for them, if any, and more importantly about the $600 low income credit.

MS. HENNEBERRY: Thank you. Any questions?

Linda?

MS. SCHOFIELD: ---. (Away from mic.)

MS. HENNEBERRY: Microphone please. Sorry.

MS. ENGLEHARDT: It is Christin Englehardt with the Health Assistance Partnership, and we work with all consumer health insurance assistance programs around the country, not just Medicare. But our primary focus has been on the SHIPs, especially because of the MMA. Thank you.

MS. HENNEBERRY: You are welcome. Thank you. Hello. Go right ahead.

Comments by Stephen Crystal

MR. CRYSTAL: Thanks, Joan. I am Steve Crystal. Kim and I work together on the research over the last three yeas that she mentioned, and her presentation was so complete and so illuminating there is really nothing much on what she covered that I need to add. But there just a couple of points that came up in the discussion that I wanted to make a couple observations about to keep in mind that came out of the subsequent discussion.

The business about what the educational needs are and the outreach and consumer education needs for this program, which is as Kim mentioned we did do a report on that is on the Commonwealth website looking at what the states are doing, and we did find that they uptake for these

programs is pretty good and that the states on the whole have done a pretty good job of outreach and consumer education. But the key thing has been I think in that experience that this something that took place over time, that people have become familiar with these programs over time. They understand them, and the ones where the uptake was best and the consumer understanding was the best were the programs that were well established. When there are major changes in programs, the consumer education needs and the level of potential confusion and so forth goes way up, and at that point it is not a minor issue anymore.

That sort of ties in with the whole broader question about these benefits, of their assuming a highly-informed consumer who is able and ready to make complicated choices, and I think from the level of sort of knowledge and experience and sophistication in this commission that hopefully this commission will provide some corrective perspective on that issue. There is a large body of research. Susan is very familiar with it. She has created part of it on the level of knowledge. The issues that come up for example with outreach for and take-up for the Medicare savings programs, which are clearly involved in this, and also what we know about this set of consumers and their ability to assimilate complicated health information

which is highly varied and we need to remember and we need to account for in whatever kind of structures are designed. The considerable number of consumers who have some level of dementia, limited health education, a limited literacy, and are really not in a position to make these kinds of complicated decisions themselves, and the states have done very well in working with that population in educating them, making sure that they got enrolled wherever possible in the programs that were appropriate for them. I think we really need as we talk about the sort of consumer choice mantra to take some of the realities into account and look at some of the research on what the actual level of ability to make these kinds of complicated evaluations are on the part of beneficiaries, and this relates very strongly to the auto-enrollment issue because there are a lot of people who will not end up enrolled in benefits that they really need unless there are some type of default or auto-enrollment processes in line.

A couple of other things quickly. The quality management issue has come up somewhat, and it came up a little bit in some of the last couple of talks, but I think we need to not lose sight of the role that the states have played in trying to improve the quality of pharmaceutical care. We need to design these systems in

ways that don't make that impossible to do. For example, if you take all of the claims, all the pharmacy claims for an individual, and split them between two systems and neither claims payment system has the full story, you make it practically impossible to do many of the initiatives for quality improvement that are becoming increasingly important. It is hard enough to do when you only have the pharmacy claims when the pharmacy is split off from the rest of the health care, and the P&T committee for one of the --- that I sit on we routinely match that data up with the physician encounters, the hospital encounters and so forth. But if we only had half of the pharmacy claims histories the whole sort of quality management program, which has really been very important for this population, would go down the tubes. So I think it is very important.

Pennsylvania is among the states that have -- and this is documented in another one of the reports that you can find on the Commonwealth website that we did as one of the states that has taken leadership in this area. New Jersey has and others have, and I think it is important that we look to the availability of data and make sure that the data are still there to allow these types of initiatives to continue for people who are enrolled in wraparound arrangements or multiple systems.

Also by the way, and I think this is an incredibly important issue, maybe slightly peripheral to the commission's mandate, but it is sort of an inside baseball thing that his going on. I think it is incredibly important from the public health point of view that these data, the massive amounts of data that are going to be generated in this process through the PDPs, not become privatized to the point where health services researchers can't make appropriate use of them to look at outcomes, to look at effectiveness. We need to be somehow moving towards a more seamless use of these data, and not a more fragmented one, so this is a big challenge.

The final point I guess is I do think there is an argument that hasn't come out yet which will come up as the issues of potentially partnering with one joint card comes up, which is that there should be some room for comity with states as to how they choose to spend their supplementary money. There is something a little odd about and there is sort of some debates about exactly the way the legislation is written as to what the states have to do and whether you have to treat every one of the possible cards the same, what it means to treat them all the same. At the very least I would think that a card that wants to be wrapped around or partner with the state would have to meet

some fairly significant information exchange requirements of that state, but somehow -- and this I guess relates in my mind to the long-term agenda of not having crowd-out and encouraging states to stay in the game and encouraging other states to come into the game, because I think there is a big potential there -- that states should not be turned into total handmaidens in this process and states should have some ability to negotiate partnerships with preferred plans in the interest of quality improvement, in the interest of working their way through some of these incredible mazes of COB that you have already starting hearing about, the technical problems.

So I think I am going to leave it at that, but I just want to express my happiness that all of you have come together and these issues are now getting the kind of really thoughtful attention that we are seeing today.

MS. HENNEBERRY: Thank you, Steve. Any questions? Reactions?

(No response.)

MS. HENNEBERRY: Okay.

MR. CHASE: I am sorry. Your point about availability of data for health services research purposes, I am just curious what have you heard so far about what the availability of that data will be? It seems the challenge

obviously is that there is a lot of private information there that people won't want to disclose. So I am assuming you are talking about it in aggregate, but has there been discussion about that being available?

MR. CRYSTAL: Right. There has been, and some of the CMS people might want to fill you in a little bit more on the history of this. But starting with Medicare there is a longstanding tradition obviously of the uniform Medicare database being used for very important health services research and outcomes studies, and those data have routinely been made available over the years to researchers. In Medicaid, CMS is getting up to speed now with its Medicaid analytic extracts program, which is now universal across states to do that. They are trying to improve things in the area of the encounter data for Medicare advantage programs, but that has been a really messy area and the quality of the data. Again, going back to the incentive issues, unless the incentive is there, unless the expectations are really clear, it tends not to happen.

My assumption originally was that when this program, when Part D went into place, because these are ultimately public dollars, well, of course this is a tremendously important resource. You know, even think about the dual eligibles. I happen to do research on dual

eligibles using the Medicare and Medicaid data. You know, does this mean that those data are going to disappear for independent researchers who want to look at outcomes and effectiveness and cost-effectiveness? At the very time that we are starting to realize that we need to understand these things, we need to make prescribing decisions and formulary decisions based on evidence pulled together on the total population. So my assumption originally had been, well, it would be a no-brainer. Obviously all those data are going to come into CMS and under suitable auspices they will be made available for research. What I have heard is that that is very much an issue of debate right now whether that is going to happen.

MS. HENNEBERRY: Okay. Other questions for Steve?

(No response.)

MS. HENNEBERRY: All right. Thank you very much.

Closing Remarks

by Joan Henneberry

MS. HENNEBERRY: Well, this concludes our open meeting of the first meeting of the commission. Let me just remind everyone the next steps. We will deliberate for about another hour-and-a-half today in closed session and

begin to digest all of the information that was provided us today, and over the next eight to 10 hours as a group we will also generate a list of questions that we still feel need to be answered in order for us to do the work that we have been charged with doing. So may very well come back to those of you who made presentations and ask for clarification. We may turn to our research partners and researchers associated with CMS and say "We need some additional information that isn't available. How can we get that?" so that we begin our work immediately. We will also as a commission as soon as the draft regulations are out on the street, we will be working with those side by side so that as we think about what are recommendations for the report and how programs should transition that they are either consistent with the regulations, or where we see big roadblocks within the regulations that we point those out as Administrator McClellan and Secretary Thompson have asked us to do. So that is what our work will be.

We will breaking into subcommittees and, as I said earlier, working very diligently over the summer so that the next time you see us we will be back here in person in Washington, DC the middle of October. We will again have an open meeting one day and then a closed meeting. We will probably actually have our closed meeting the first day so

we can put fine-tuning and final touches to our recommendations and then put those out there in an open meeting the following day.

But there will be a lot of work going on over the summer. We welcome your comments and input. As I mentioned earlier, please contact Marge and see her if you need her contact information if there are other things that you would like to provide to us as we do our work over the summer.

So I would like to thank all of our CMS folks and our contractor for helping bring us here and making this a productive day. Thank you all for coming and staying all day, and a special thanks to all of our presenters who provided us with very vital, helpful information as we begin our deliberations. Thank you all.

(Applause.)

(Whereupon, the open session was adjourned at 3:25 p.m.)